Maternal and Child Health Services Title V Block Grant

Florida

FY 2022 Application/ FY 2020 Annual Report

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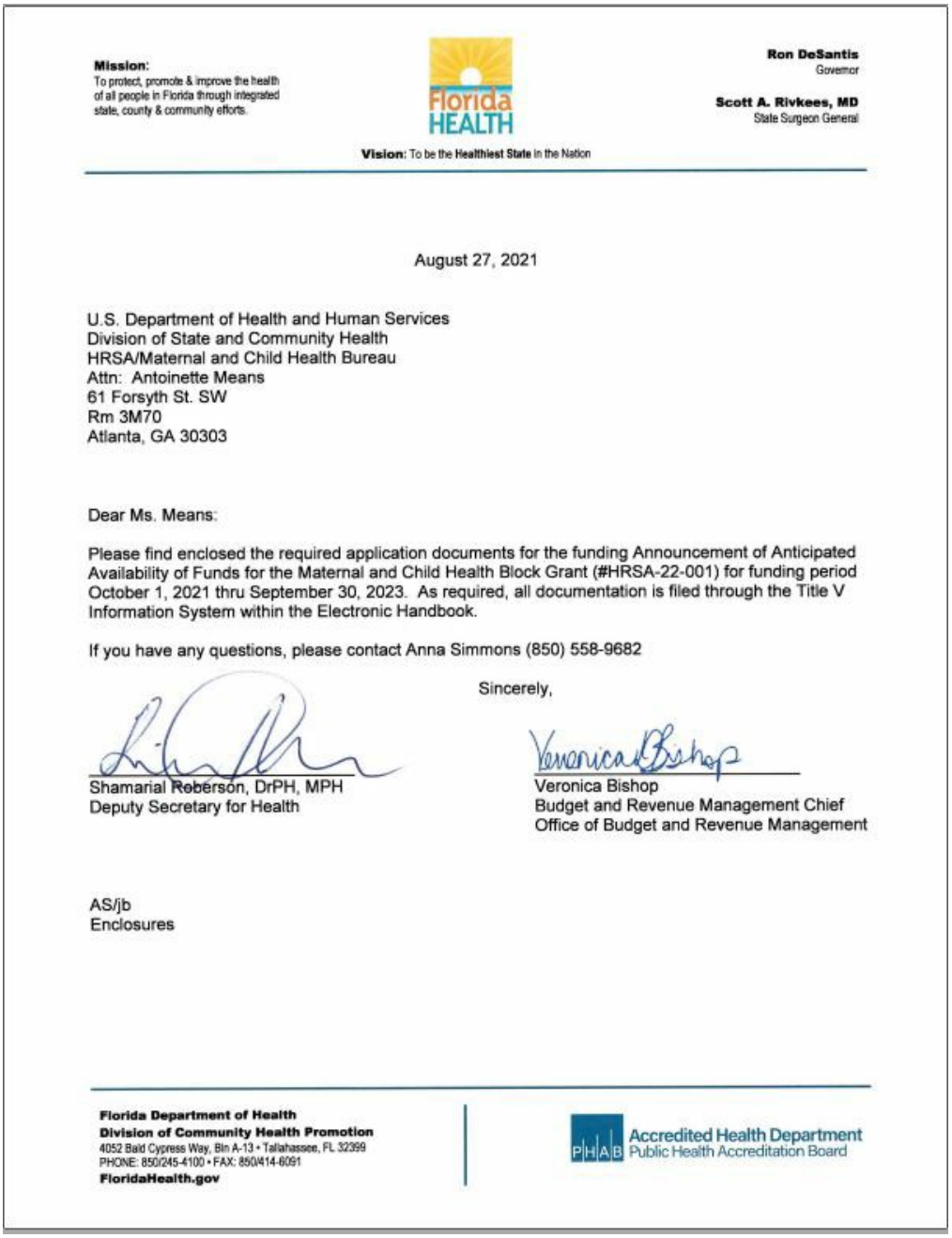
Table of Contents

I. General Requirements

I.A. Letter of Transmittal



Mission:
To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.

Florida HEALTH

Ron DeSantis
Governor

Scott A. Rivkees, MD
State Surgeon General

Vision: To be the **Healthiest State** in the Nation

August 27, 2021

U.S. Department of Health and Human Services
Division of State and Community Health
HRSA/Maternal and Child Health Bureau
Attn: Antoinette Means
61 Forsyth St. SW
Rm 3M70
Atlanta, GA 30303

Dear Ms. Means:

Please find enclosed the required application documents for the funding Announcement of Anticipated Availability of Funds for the Maternal and Child Health Block Grant (#HRSA-22-001) for funding period October 1, 2021 thru September 30, 2023. As required, all documentation is filed through the Title V Information System within the Electronic Handbook.

If you have any questions, please contact Anna Simmons (850) 558-9682

Sincerely,

Shamarial Roberson, DrPH, MPH
Deputy Secretary for Health

Veronica Bishop
Budget and Revenue Management Chief
Office of Budget and Revenue Management

AS/jb
Enclosures

Florida Department of Health
Division of Community Health Promotion
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FloridaHealth.gov

PHAB Accredited Health Department
Public Health Accreditation Board

I.B. Face Sheet

The Face Sheet (Form SF424) is submitted electronically in the HRSA Electronic Handbooks (EHBs).

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix F of the 2021 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms,"* OMB NO: 0915-0172; Expires: January 31, 2024.

II. Logic Model

Please refer to figure 4 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms," OMB No: 0915-0172; Expires: January31, 2024.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

The Florida Department of Health (FDOH) is responsible for administering the Title V Maternal and Child Health Block (MCHB) Grant, encompassing the MCH and Children and Youth with Special Health Care Needs (CYSHCN) programs. These programs fall under the Division of Community Health Promotion (CHP) and the Office of Children's Medical Services (CMS) Managed Care Plan and Specialty Programs respectively. Title V leaders in CHP and CMS meet monthly to coordinate efforts across all programs.

Title V programs serve a large, diverse population. Florida is the third most populous state in the nation, with an estimated population of 22 million people, of which 75.1% percent are white; 16.1 percent are black; and 5.7 percent are other races or two or more races. Of the total population by ethnicity, 25.6 percent are Hispanic. The racial, ethnic, and cultural diversity of Florida's population creates unique challenges as well as opportunities.

Priorities to meet the needs of the Title V population include the promotion of safe sleep behaviors, breastfeeding, and smoking cessation to reduce poor birth outcomes; encouraging children to be physically active; improving access to care for women; and dental care access for children and women. Priorities for CYSHCN include access to medical homes/primary care and improving access to mental health services for all children. Corresponding strategies and activities are intentionally inclusive in the areas of health equity, family partnership, transition, life course, workforce and essential public health services.

The five-year needs assessment, and continual assessment during interim years, drives Florida's Title V programs. State priorities were selected through the needs assessment process and cover each of the five health domains. These priorities also determine the nine national performance measures (NPMs) chosen for programmatic focus.

Strategies identified to address priority needs and selected performance measures are implemented through a variety of mechanisms, including statewide projects administered through the state health office, Schedule C funding through a statement of work with county health departments (CHDs), contracts with academic and university partners, Florida's Perinatal Quality Collaborative (FPQC), Healthy Start Coalitions, and other partners and stakeholders.

The Title V program plays an important role in supporting and ensuring comprehensive, coordinated, and family-centered services. These efforts begin with reviewing epidemiologic research and reports and collecting and studying data to ensure our efforts and decision making are data driven and factually relevant. The Title V program collaborates with other programs within the FDOH to ensure comprehensive, coordinated services are available to the people of Florida, particularly women, pregnant women, infants, and children (including CYSHCN). The Bureau of Family Health Services' MCH Section and the Office of CMS Managed Care Plan and Specialty Programs have primary responsibility for the Title V application and oversight of Title V activities.

Under the leadership of the State Surgeon General, the Title V program works with a diverse group of public and private partners across the state who make up Florida's public health system, including a range of stakeholders, such as state and local government agencies, health care providers, employers, community groups, universities and schools, nonprofit organizations, and advocacy groups. State examples include county health departments, the FPQC, the Agency for Health Care Administration (AHCA), the Department of Children and Families (DCF), the Department of Education (DOE), the Florida Hospital Association, the March of Dimes, and Healthy Start Coalitions. Partners on the national level include, the Association of Maternal & Child Health Programs, National Maternal Child Health Workforce Development Center, CityMatCH, Centers for Disease Control and Prevention (CDC), and the Association of State and Territorial Health Officers. CMS partnerships include the MCHB funded training programs at the University of Florida's Pediatric Pulmonary Center, the University of South Florida's Department of Pediatrics Adolescent Medicine and College of Behavioral & Community Sciences, the University of Miami's Mailman Center for Child Development, the Family Café, and the Family Network on Disabilities of Florida.

The CYSHCN program vision is that every child and youth with special health care needs has access to high quality, evidence-based, family-centered systems of care, regardless of health insurance type. To influence NOM 17.2, the percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system, the CYSHCN framework includes five key strategies: 1) Transform pediatric practices into patient-centered medical homes 2) Build the behavioral health integration capacity of pediatric primary care clinicians to identify and treat common behavioral health conditions 3) Address community integrated system building in Florida's diverse regions 4) Improve access and quality through contracts with specialty networks that have condition-specific expertise (e.g., diabetes, sickle-cell disease) 5) Collaboratively partner with CMS Health Plan, a Medical Managed Assistance Plan that serves children with medical complexities.

CMS continues to address the needs of CYSHCN and their families through population health strategies that strengthen the system of care, especially for children with medical complexities. In the wake of COVID-19, children are behind on vaccines and have increased mental health needs, requiring increased program efforts to expand access to patient centered medical homes

and access to mental health treatment. This includes ensuring that underserved areas, are prioritized for expansion. As foundational elements, the Standards for Systems of Care for Children and Youth with Special Health Care Needs, Version 2 and tasks that address identified CYSHCN priorities have been woven into the majority of the FDOH's CYSHCN contracts. This includes the implementation of quality of life measurement tools and how programs plan to use the resulting information for quality improvement activities. To engage multiple sectors and community partners to generate collective impact and improve social determinants of health, CMS' regional approaches include public health detailing, annual community assessments, and the formation of regional networks for access and quality.

Specific to its role as a health plan option for CYSHCN enrolled in Title XIX or Title XXI health insurance, CMS partnered with WellCare of Florida in February 2019. Approximately 91,000 CYSHCN have enrolled in this health plan built on the Standards for Systems of Care for CYSHCN. Children and families receive specialized care coordination services, as well as expanded benefits to address family needs and social determinants of health such as caregiver behavioral health services, non-medical transportation, over-the-counter stipends, swimming lessons, and home and grocery allowances.

MCH has also made strides to address quality of care and access to services, at a time when the need for care for the Title V population seems ever more prevalent. Our MCH program remains focused on the racial disparity evidenced by our indicators and exhibited in poorer health outcomes for certain races. MCH continues to focus on social determinants of health to address the disparity of people who are disadvantaged through factors such as family income or education, or simply the communities in which they live and work.

The FDOH's ongoing efforts to address avoidable inequities, historical and contemporary injustices, and to eliminate health disparities, would not be possible without the leadership of our county health officers and the cooperation of our valuable partners at the federal, state, local, tribal, and territorial levels. Following is a discussion of our current priorities and corresponding performance measures and justification for selection through our statewide needs assessment process:

Domain: Women/Maternal Health
NPM 1: Percent of women, ages 18 through 44, with a past year preventive medical visit.
ESM 1.1: The number of interconception services provided to Florida's Healthy Start Program clients.
State Priority: Improve access to health care for women to improve preconception and interconception health, specifically women who face significant barriers to better health.
Significance: Women's health, at all ages of the lifespan and for those whose circumstances make them vulnerable to poor health outcomes, is important and contributes to the well-being of families. The Title V program focuses on preconception/interconception health, recognizing the importance of improving the health of all women of reproductive age to ensure better birth outcomes and healthier babies.

NPM 14.1: Percent of women who smoke during pregnancy.
ESM 14.1: The number of Smoking Cessation Reduction in Pregnancy Treatment (SCRIPT) services provided to Florida's Healthy Start Program clients.
State Priority: Promote tobacco cessation to reduce adverse birth outcomes and secondhand smoke exposure to children.
Significance: Smoking during pregnancy increases the risk of miscarriage, certain birth defects, premature birth, and low birth weight. Smoking is also a risk factor for sudden infant death syndrome (SIDS), as secondhand smoke doubles an infant's risk of SIDS.

Domain: Perinatal/Infant Health
NPM 4: A) Percent of infants who are ever breastfed, and B) Percent of infants breastfed exclusively for 6 months.
ESM 4.1: The number of Florida hospitals achieving the Baby Steps to Baby Friendly hospital designation.
State Priority: Promote breastfeeding to ensure better health for infants and children and reduce low food security.
Significance: There is a clear link to the state's priority to promote breastfeeding as a means of ensuring better health and reducing low food security. Breastfeeding is recognized as a major health benefit to infant and mother as well as an enhancement of maternal/child bonding.

NPM 3 Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU).
ESM 3.1 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)
State Priority: Promote activities to improve the health of children and adolescents and promote participation in extracurricular and/or out-of- school activities in a safe and healthy environment.
Significance: Very low birth weight infants (<1,500 grams) are the most fragile newborns with a risk of death over 100 times higher than that of normal birth weight infants (≥2,500 grams). VLBW infants are significantly more likely to survive and thrive when born in a facility with a level-III Neonatal Intensive Care Unit (NICU), a subspecialty facility equipped to handle high-risk neonates.

NPM5: A) Percent of infants placed to sleep on their backs, B) Percent of infants placed to sleep on a separate approved sleep surface, C) Percent of infants placed to sleep without soft objects or loose bedding. ESM 5.2: The number of birthing hospitals that are Safe Sleep Certified.
State Priority: Promote safe and healthy infant sleep behaviors and environments, including improving support systems and the daily living conditions that make safe sleep practices. challenging.
Significance: Sleep-related deaths, including suffocation, asphyxia, and entrapment; and ill-defined or unspecified causes of death, remain a concern for families in Florida. Focusing on a safe sleep environment can reduce the risk of all sleep-related infant deaths, including SIDS.

Domain: Child Health

NPM 8.1 and 8.2 : Percent of children ages 6-11 and adolescents ages 12-17 who are physically active at least 60 minutes per day.

ESM 8.1: The number of school districts that apply for the evidence-based Florida Healthy School District recognition State Priority: Promote activities to improve the health of children and adolescents and promote participation in extracurricular and/or out-of-school activities in a safe and healthy environment.

Significance: Studies show that for many children, a decline in physical activity begins in middle school, but children who continue to be physically active through high school have a much better chance of being physically active adults. Focusing on children and adolescents to increase physical activity can have a tremendous impact on improving health throughout the lifespan.

SPM 2: The percentage of low-income children under age 21 who access dental care

State Priority: Improve dental care access for children and pregnant women.

Significance: Oral health is vitally important to overall health and well-being. Good oral health habits and access to routine dental care should be established early in life. Poor oral health can affect school attendance and a child's ability to learn.

SPM 3: The percentage of parents who read to their young child.

State Priority: Address the social determinants of health that influence the relationship between health status and biology, individual behavior, health services, social factors, and policies.

Significance: Encouraging parents to read to their child has a positive impact on children, including but not limited to, increased positive parenting, improvement in the parent-child bond, and improved language development in children.

Domain: Adolescent Health

NPM 9: Percent of adolescents, ages 12-17, who are bullied or who bully others.

ESM 9.1: The number of students who participate in an evidence-based program that promotes positive youth development and non-violence intervention skills.

State Priority: Promote activities to improve the health of children and adolescents and promote participation in extracurricular and/or out-of-school activities in a safe and healthy environment.

Significance: To grow and develop in good health, adolescents need information, opportunities to develop life skills; and safe and supportive environments. They also need opportunities to meaningfully participate in the design and delivery of interventions to improve and maintain their health. Bullying is a serious detriment to a child's health, sense of well-being, safety, education, and emotional development; and greatly increases the risk of self-injury and suicide.

Domain: Children and Youth with Special Health Care Needs

NPM11: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home.

ESM 11.1: Number of FDOH team members, providers (pediatric, family practice, and adult), families, family partners, and other partners serving CYSHCN in Florida receiving education or technical assistance about the patient-centered medical home model and related topics that impact the health and wellness of CYSHCN.

ESM 11.2: Number of caregivers of CYSHCN in Florida who perceive themselves as a partner in their child's care.

ESM 11.3: Percentage of providers in underserved geographic areas that received formal technical assistance through UCF HealthARCH program that became designated patient-centered medical homes.

ESM 11.4: Number of Adult Care Providers/Practices that accept CYSHCN transitioning to adult care.

SOM: Percent of family satisfaction with access to care received in a patient-centered medical home and primary care for children that have special health care needs

State Priority: Increase access to medical homes and primary care for CYSHCN.

Significance: A patient-centered medical home (PCMH) provides accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective medical care. It is especially advantageous for CYSHCN as they require coordination of care between providers.

SPM 1: The percentage of children who need mental health services that actually receive mental health services.

ESM 1.1: Number of FDOH team members, providers, (pediatric, family practice, and adult), families, family partners, and community service providers receiving education or technical assistance about accessing or providing access to behavioral health services.

ESM 1.2: Number of providers that have initiated integrating behavioral health services.

ESM 1.3: Number of activities identified that support families in enhancing mental health protective factors and build resilience.

State Priority: Improve access to appropriate mental health services to all children.

Significance: Access to behavioral/mental health services is a priority need. Without early diagnosis and treatment, children with mental health conditions may have problems at home, school, and socially.

III.A.2. How Federal Title V Funds Complement State-Supported MCH Efforts

Federal Title V funding provides invaluable flexibility in how states are able to compliment state and other funding resources to meet the needs of their population. This allows states to determine what strategies to implement and what health concerns in their state to address. An example of this in Florida is investing in an Opioid Coordinator.

In 2018 Florida was awarded a grant from the Association of State and Territorial Health Officers (ASTHO) for the Opioid Use Disorder, Maternal Outcomes, and Neonatal Abstinence Syndrome Initiative (OMNI). Through this grant, an Opioid Coordinator was hired. This coordinator came to the initiative with 20 plus years working in maternal and child health at the local and state level. The coordinator was able to make progress on initiatives and the FDOH was able to continue this momentum when the grant was over by using Federal Title V funding to support this position.

The MCH Section continues to convene partners to create networks that assist in funding collaborative work and support quality research about what works and what changes can be made at the systems level to improve health outcomes. This approach requires partnership with other funders and organizations able to make a difference on the issue in question on a larger scale. Scaling successful interventions is toobig a job for any one funder to successfully take on.

Systems change is a long process and partners understand the need to be willing to fund supportive efforts for the long-term and encourage the inevitable learning, adaptation, and even failure that takes place over time. This allows partnersto see themselves as part of the solution and consider the role they play as well as the return on investment, both from a business stance and overall population effect.

The FDOH continues to successfully implement system changes through some of its partnerships with the Florida Perinatal Quality Collaborative (FPQC), Florida Hospital Association, Florida State University, University of Florida, Florida Association of Healthy Start Coalitions, Nurse Family Partnership, the Agency for Health Care Administration, Florida Department of Children and Families, Florida Department of Education,

III.A.3. MCH Success Story

Florida's Maternal Mortality Review Committee is a multi-disciplinary team that examines pregnancy-related deaths (PRD) to recommend and promote actions to address patient and community factors, provider and facility practices, and health system issues in order to prevent these deaths. PRD is a death during pregnancy or within one year of delivery from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition.

In contrast to the nation, Florida's pregnancy-related mortality ratio (PRMR) has decreased over the past decade with significant improvements in non-Hispanic Black and Hispanic women. In 2017, Florida's PRMR of 15.7 was lower than the national ratio of 17.3. Overall, the PRMR in Florida decreased 29% from 2009-2013 to 2014-2018 ($p<0.001$). For non-Hispanic Black women, the PRMR decreased 37% from 46.6 to 29.4 deaths per 100,000 live births over the same time period ($p=0.002$). Similarly, the PRMR decreased 42%, from 12.8 to 7.4 in Hispanic women ($p=0.04$). Although not significant, non-Hispanic White women decreased 8% from 15.8 to 14.5. Consequently, the Black-White disparity decreased from a value of 3.0 to 2.0. The most common underlying causes of PRD during the study period included: hemorrhage (21.1%), infection (15.4%), hypertensive disorders (11.8%), and other causes; the last three showed significant decreases in ratios over the two time periods (each $p<0.01$). Although not significant, the hemorrhage ratio decreased after a prior decade of increase.

There are several reasons for this improvement. First, Florida has a robust mortality review committee which comprehensively reviews all PRD based on good evidence to show that these committees strengthen public health surveillance. Florida's review committee identified hemorrhage and hypertensive disorders as prevention priorities and developed Urgent Maternal Mortality Messages based on findings and trends and has distributed these to obstetrical providers and hospitals throughout the state. Additionally, the Florida Perinatal Quality Collaborative and other state partners have launched obstetric hemorrhage and hypertension quality improvement initiatives. Finally, national initiatives are addressing prevention and systems improvement to eliminate preventable maternal mortality. Ensuring a multi-disciplinary mortality review and using statewide resources in a multi-pronged approach has shown to be effective in decreasing Florida's PRMR.

III.B. Overview of the State

To effectively plan for improving health, it is important to understand health is shaped by the social, economic, and environmental conditions in which we live, and the available and accessible community resources. It is necessary to address the conditions that impact our health rather than only treating medical conditions after they occur. This section discusses the principal characteristics important to understanding the health status and needs of not only Florida's population but more specifically the MCH and CYSHCN population.

According to statewide population estimates conducted by the Florida Legislature, Office of Economic and Demographic Research, Florida has a total population of 22.0 million citizens in 2021, following only California and Texas as the third most populous state. Between 2011 and 2021, Florida's population increased by 16.0 percent. The most recent demographic data for April 1, 2021, shows 77.2 percent of Florida's population is white,17.0 percent black, and 5.8 percent other races, mixed race, or unknown. Of the total population by ethnicity, 26.7 percent are Hispanic and 73.3 percent non-Hispanic. More than half of the state's population (51.3 percent) is between the ages of 25-64 and 27.8 percent are between the ages of 0-24. Individuals 65 and older comprise 20.9 percent of the state's population compared to just 15.2 percent in this age group nationally in July 1, 2016. A greater percentage of health care resources are expended on the elderly population in Florida compared to other states.

The mission of the Florida Department of Health (FDOH) is to protect, promote, and improve the health of all people in Florida through integrated state, county, and community efforts. The FDOH's goal is to be the healthiest state in the nation. Our values are illustrated by the acronym ICARE:

Innovation: We search for creative solutions and manage resources wisely.
Collaboration: We use teamwork to achieve common goals and solve problems.
Accountability: We perform with integrity and respect.
Responsiveness: We achieve our mission by serving our customers and engaging our partners.
Excellence: We promote quality outcomes through learning and continuous performance improvement.

Accomplishing our mission begins with fundamental plans of action. The FDOH's State Health Improvement Plan(SHIP) establishes goals for the public health system, which includes state and local government agencies, health care providers, employers, community groups, universities and schools, nonprofit organizations, and advocacy groups. The FDOH uses a collaborative planning process to foster shared ownership and responsibility for the plan's implementation, with the goal of efficient and targeted collective action to improve the health of Floridians.

The FDOH is leading a diverse group of stakeholders to build Florida's SHIP for 2022-2026. This includes conducting a comprehensive state health assessment to identify the most important health issues. The SHIP Steering Committee is currently meeting to set five-year priorities based on the health issues and strategic opportunities identified in the assessment.

To keep projects on track SHIP objectives will continue to have Priority Area Workgroups that meet quarterly. These workgroups are comprised of partners around the state who share updates on their projects that are impacting the SHIP goals. This time is also used to identify any barriers individuals may be experiencing and problem solving to overcome these barriers.

Additional plans include the Agency Strategic Plan, which provides a unified vision and framework for action. This plan positions the FDOH to operate as a sustainable integrated public health system and provide Florida's residents and visitors with quality public health services. The FDOH is actively developing a new agency strategic plan for the coming five years. The Long-Range Program Plan provides the framework and justification for the agency budget. It is a goal-based plan with a five-year planning horizon and focuses on agency priorities in achieving the goals and objectives of the state.

In 2020, the FDOH received re-accreditation as an integrated Department of Health through the Public Health Accreditation Board (PHAB). This seal of accreditation signifies that the unified FDOH, including the state health office and all 67 county health departments, has been rigorously examined and meets or exceeds national standards for public health performance management and continuous quality improvement. The FDOH was required to provide examples of quality improvement activities to demonstrate conformity with the PHAB standards and to maintain accreditation status.

The Title V MCH and CYSHCN directors, along with MCH and CMS staff, utilize various methods to determine the importance, magnitude, value, and priority of competing factors that impact health services delivery. The five-year needs

assessment and continual assessment during interim years provides valuable direction. Many of the FDOH's priorities, policies, and services originate through legislative bills, statutory regulations, administrative rules, and directives from the State Surgeon General. Priorities for improving public health are addressed through a variety of plans that address collaboration with our partners as well as internal agency priorities. The Title V program receives input and advice from statewide partnerships, stakeholders, and other agencies and organizations.

Comprehensive community health assessment and health improvement planning are the foundations for improving and promoting healthier communities. County health departments use a common process for collecting, analyzing, and using data to educate and mobilize communities, develop priorities, gather resources, and plan and implement actions to improve public health.

At the state and local levels, three critical assessments provide the basis for action: community health status assessment, forces of change assessment, and local public health system assessment using the National Public Health Performance Standards Program. Assessment findings inform the selection of strategic community health priorities. Goals, strategies, and measurable objectives are used to develop a community health improvement plan that includes implementation strategies and action plans. Two important, tangible products of these efforts are state and community health status profile reports and state and community health improvement plans, resulting in state and local documents reflecting each area's needs and priorities.

The FDOH has also adopted the National Association of City and County Health Officials' Protocol for Assessing Community Excellence in Environmental Health (PACE EH). For several years, the Bureau of Environmental Health has encouraged county health departments to work with their communities and address environmental health concerns. Collectively, county health departments who have implemented PACE EH in communities have become a national model, and provided evidence that communities can identify environment and urban planning issues as environmental health issues and address the social determinants of health. All projects are designed to open the lines of communication between the county health departments and affected communities. The PACE EH initiative is also supported through the FDOH's Florida Healthy Babies program.

Children and youth with special health care needs is the primary focus of the Office of Children's Medical Services Managed Care Plan and Specialty Programs (CMS). Florida has 4.2 million children, of whom approximately 770,000 are CYSHCN. Children with medical complexity, a subset of CYSHCN, number approximately 42,000 children; despite their small numbers, they account for a third of health care spending, 40 percent of deaths, and 25 percent of hospital days. Florida has 18 pediatric children's hospitals statewide to serve the acute, chronic, and complex needs of children. Despite this large number of hospitals, there is remarkable geographic variation in access to specialty care.

To ensure that all CYSHCN receive care in a well-functioning system, CMS engages in a wide variety of activities which includes five main leverage opportunities: (1) Transform pediatric practices into patient-centered medical homes; (2) Build behavioral health integration capacity with pediatric primary care providers; (3) Address community integrated system building in Florida's diverse regions; (4) Improve access and quality through contracts with specialty networks that have condition-specific expertise; and (5) Collaboratively partner with the CMS Plan a managed care plan specifically designed for CYSHCN. CMS partners with the Florida's only designated National Committee for Quality Assurance (NCQA) partner in quality, the University of Central Florida's Health Advancing Resources to Change Health Care (UCF HealthARCH). Annually UCF provides 1:1 technical assistance to support pediatric practices in their Patient Centered Medical Home (PCMH) practice transformation, and continued assistance for renewal requirements. To expand to a population health approach, a learning action network is being developed and readiness assessments will be used to stage providers for the most appropriate PCMH activity.

1. CMS partners with the Florida's only designated National Committee for Quality Assurance (NCQA) partner in quality, the University of Central Florida's Health Advancing Resources to Change Health Care (UCF HealthARCH). Annually UCF provides 1:1 technical assistance to support pediatric practices in their Patient Centered Medical Home (PCMH) practice transformation, and continued assistance for renewal requirements. To expand to a population health approach, a learning action network is in development and readiness assessments will be used to stage providers for the most appropriate PCMH activity.

2. Florida has an estimated 400,000 children and youth with one or more mental health conditions, and only about half receive treatment. With the goal to build capacity of primary care providers to identify and treat common pediatric behavioral or mental health conditions (e.g. ADHD, anxiety, depression), CMS partnered with five university system partners across the state to develop pediatric mental health care access teams. The aim is to increasing access through telehealth consultations services, while providing skill-building training and technical assistance so that primary care providers can learn to integrate behavioral health services in their practice. These regional partners, along with additional state and system stakeholders, come together to form Florida's Pediatric Mental Health Collaborative, a statewide network that looks at pediatric mental health system gaps and needs, including quality improvement and sustainability issues.

3. An informed strategy for community systems approaches is the integration of multisector service systems that work together on community needs, including social determinates of health. CMS's infrastructure is built on six regional programs that provide the evidenced based practice of public health detailing, providing outreach, education and technical assistance to community partners and health care providers. These regional teams link community and state resources, create a pipeline of providers for PCMH practice transformation and Behavioral Health integration, ensuring that local health planning includes CYSHCN. As such they complete an annual regional assessments, so that state CYSHCN priorities and strategies are informed by regional variation and emerging needs are addressed early. An additional strategy for integrated community system building, includes CMS's regional network for access and quality model. CMS partnered with two community systems to pilot this model, results will inform future community infrastructure building for CYSHCN.

4. CMS has 59 vendors statewide to ensure that CYSHCN have access to high-quality health care. A subset of this includes tertiary care systems, that serve seven specific conditions (Behavioral Health, Chronic Kidney, Craniofacial, Endocrine, Hematology- Oncology, HIV/AIDS and Pulmonary). The focus of these contracts has shifted away from direct care services, and individual institutional approaches to building an integrated system of care, forming statewide networks for access and quality (SNAQ). A collaborative learning approach includes 32 quality improvement teams, across the state from their various institutional programs, that come together to work on common quality improvement projects through peer to peer learning and technical assistance with the National Institute for Children's Health Quality (NICHQ).

5. CMS administers a Medicaid Managed Care plan and CHIP option for clinically eligible CYSHCN, known as the CMS Plan operated by contracted vendor. Effective February 1, 2019 CMS implemented its new health care delivery system model which was conceived with comprehensive stakeholder input at the family, provider, and community levels; as well as state and national experts. Over 91,000 of Florida's CYSHCN are currently enrolled in the CMS Health Plan, receiving direct care services for their medical, behavioral, and developmental needs. The CMS Health Plan provides increased payments to high-performing providers and enhanced care coordination services to families. To address social determinates of health, the CMS Plan offers families "in lieu of" services and enhanced benefits, such as over-the-counter stipends, home and grocery allowances, non-medical transportation and caregiver behavioral health services. The CMS Plan is a valuable partner for the Title V CYSHCN program, and bi-directional communication help inform each other of needs, trends and leverage opportunities to improve the service delivery system for CYSHCN in Florida. For example, a Title V initiative to review quality measures led to the inclusion of quality of life measures in the CMS Plan; this innovative approach promises to help ensure that health care services are aimed at addressing critical child and family needs. In addition, Title V and the CMS plan are working on a pilot model to look at value based payment models for transitioning youth to adult health care services.

The Office of Minority Health and Health Equity (OMHHE), led by the Senior Health Equity Officer, serves as the FDOH's coordinating office for consultative services and training in the areas of cultural and linguistic competency, partnership building, program development and implementation, and other related comprehensive efforts to address the health needs of minority and underrepresented populations. The OMHHE promotes the integration of culturally and linguistically appropriate services within health-related programs across the state to ensure the needs of the state's racial and ethnic minority communities are addressed, as well as the needs of people who are lesbian, bisexual, gay, transgendered (LGBT).

The FDOH established a Health Equity Program Council to focus on the issue of health equity. The council is comprised of county health department officers and leaders in the state health office. The council guides county health department and state health office efforts by monitoring emerging research and expanding and implementing evidence- based practices statewide.

The first project of the Health Equity Program Council was Florida's Healthy Babies Initiative, the FDOH's direct response to focus on the black-white infant mortality gap. Annually, the FDOH invests $1.5 million in Title V funding. Funding was initially provided to the county health departments to conduct an enhanced data analysis on infant mortality, including an environmental scan of existing pertinent programs, and to host a community action-planning meeting to examine disparities in infant deaths, the role of social determinants of health, and to propose local action. The program has evolved

since then. County health departments are encouraged to use their data to inform projects and strategies that are implemented to address infant mortality in their communities. Workplans are completed each year and quarterly updates are submitted detailing the progress that has been made.

Encouraging physical activity and healthier food choices has a positive impact on birth outcomes and child health. Women who are healthier before and during pregnancy lessen the risk of maternal and infant morbidity and mortality. Several factors determine what people eat, but access to healthy food and beverages has a major influence. Finding healthy food is not always convenient. Studies have found that people buy food that is readily available. Today, it is often the case that communities with the highest rates of obesity are also places where residents have few opportunities to conveniently purchase nutritious, affordable food. The FDOH has a SNAP Education grant that helps teach people to shop for and cook healthy meals. This happens at the CHD level.

The rate of pregnant women diagnosed with opioid use disorder (OUD) during labor and delivery in the U.S. more than quadrupled from 1999 to 2014, according to a 2018 analysis by the Centers for Disease Control and Prevention (CDC). In Florida, the rate increased from 0.5 per 1,000 delivery hospitalizations in 1999 to 6.6 in 2014. The FDOH has several initiatives to address this.

To identify Neonatal Abstinence Syndrome (NAS) cases, the FDOH currently uses a passive case ascertainment methodology that relies on linked administrative datasets and diagnostic codes indicative of NAS. First, birth certificate records from the Bureau of Vital Statistics are linked to the infant's birth hospitalization record, which is provided as part of quarterly submission of inpatient hospital discharge data by hospitals to the Agency for Health Care Administration (AHCA). Each discharge record includes International Classification of Diseases, Clinical Modification (ICD) diagnosis codes documented during the hospital encounter. The prevalence rates of NAS in Florida have increased from 2.8 to 67.3 per 10,000 live births from 1998-2015. After 2015, the prevalence of NAS decreased to 56.3 per 10,000 live births in 2019. This prevalence rate equates to an average of 1,400 cases of NAS per year in Florida since 2011. (most recent data available). Over the last two years the statewide trend in NAS rates has decreased, from a rate of 67.2 per 10,000 live births in 2017 to the current rate of 56.3 per 10,000 live births in 2019.

Florida shares borders with the reservations of two tribal governments, the Seminole Tribe and the Miccosukee Tribe. These governments have their own public safety and emergency services for reservation residents, but a substantial portion of their tribal citizens live outside the reservation boundaries. The FDOH established the American Indian Health Advisory Committee to provide guidance on issues impacting American Indian populations in Florida. The committee consists of representatives from tribes and stakeholders serving American Indian communities and staff from the Office of Minority Health and Health Equity. Florida is also home to many non-governmental tribal communities, whose members may be spread out geographically but who gather frequently to maintain their community's identity, culture, language, traditional knowledge, and traditional ways. These groups do not have government status either as a preference, or because their structure is not suited to political governance, or because they cannot provide documentation that they maintained a tribal government during the years that it was illegal to do so. A subset of this category would be American Indian Christian Churches, which bring members and descendants of various American Indian nations together around a shared faith practice that incorporates inter-tribal practices in their worship. Another subset of this category would be American Indian associations that organize cultural gatherings that are open to visitors. Yet another subset are American Indian associations concerned with activism in favor of American Indian causes.

Per the 2020 Census, individuals in Florida identifying as only Native American comprise a total of 107,389. In addition, Native Americans experienced a 50.3 percent increase in identification as Native Americans (alone) over the 10-year (2010-2020) period. This is a greater increase than white or black (alone) over the same period.

Typically, Florida is a temporary home to well over 100 million tourists and visitors each year, which presents challenges to the state's public health system. Due to the COVID-19 pandemic, the number of visitors dropped from 131.4 million in 2019 to 79.4 million in 2020. However, in the first six months of 2021, Florida welcomed nearly 59 million tourists, up from 39.9 million during the first six months of 2020. This is a 47.9 percent increase. The 2021 estimate, includes 57.2 million domestic visitors, 1.7 million overseas visitors and 0.1 million Canadian visitors. Migrant farm workers and unauthorized immigrants also have a significant impact on the state's public health services and resources. According to the most recent data, Florida was home to 732,000 unauthorized immigrants in 2018. California and Texas are the only states with greater numbers of unauthorized immigrants.

The racial, ethnic, and cultural diversity of Florida's population creates unique challenges as well as increased opportunities. This diversity makes Florida a more interesting place to live, work, and play. The Title V program, along with

private and public health providers, contributes to meeting the challenges that come with the state's diverse group of residents, immigrants, tourists, and visitors. The FDOH supports the culturally diverse MCH population by tailoring services provided through the Title V program to meet the needs of different cultures. Educational materials are developed in English, Spanish, and Haitian Creole. The FDOH contracts with Language Line Services to provide telephonic interpretation services in over 180 languages, allowing a client to communicate with a health care provider through a conference or three-way calling system. Language Line Services also provides written translation services in over 100 languages and translates documents into multiple languages.

The health of the economy plays a major role in the health status of the state's MCH population. The economy in Florida has been recovering since the onset of COVID19. The average annual wage of $50,020 in Florida currently stands at 88.8 percent of the national average in May 2020. Florida's economy is heavily reliant upon the service-related industry, where minimum wage jobs with little or no benefits are more the norm than the exception. In November, 2020 voters approved a minimum wage increase to $15.00 an hour. This increase will scale up over the next six years. While this is a move in the right direction, until this increase is fully realized, many individuals and families continue to struggle to meet their basic needs. Groups disproportionately affected are female-headed households and people who are Black, Hispanic, living with a disability, and unskilled recent immigrants. According to the latest final numbers from the U.S. Bureau of Labor Statistics, Florida's unemployment rate was 5.0 percent in June 2021, this is lower than the national employment rate of 5.9 percent. However, prior to the COVID-19 pandemic, Florida had historically low unemployment rates Florida had a four-year adjusted cohort graduation rate for public high schools of 86.9 percent in 2018-19. In comparison, the corresponding national rate was 85.8 percent during the 2018-19 school year. Florida's standard diploma is a rigorous credential for which standards and testing requirements have periodically increased. As states have different criteria for awarding a standard diploma, comparing rates among states is problematic.

Florida's total area is 58,560 square miles. Driving from Pensacola in the western panhandle of Florida to Key West at the southernmost point is nearly an 800-mile journey. The 1,200 miles of coastline become a target during hurricane season, and 2,276 miles of tidal shoreline are subject to concerns regarding water quality and fish and wildlife habitat degradation. With the threat of tropical depressions and hurricanes looming every summer, the FDOH takes emergency preparedness seriously for all sorts of possible threats or disasters. Most recently this includes preparation and response as a result of the COVID-19 pandemic. Florida's Public Health Preparedness effort is an excellent model of public-private cooperation. Well organized public-private partnerships benefit from the strengths and competencies of both systems.

When hurricanes approach, the FDOH operates and staffs Special Needs Shelters (SpNS) to allow people with special or complicated medical needs, their family members, and aides to safely shelter from the storms, with nurses on hand to assist with their needs. At-risk or vulnerable populations include those groups whose needs may not be fully integrated into planning for disaster response. These populations include persons with physical, cognitive, or developmental disabilities. Included in this group are persons with limited English proficiency, the geographically or culturally isolated, medically or chemically dependent, homeless, frail elderly, children, and pregnant women. Meeting the needs of vulnerable populations during or following a disaster is a key component of public health and medical preparedness planning. FDOH staff collaborate with the county health departments in planning for disasters, staffing the SpNS around the state, and assisting in recovery efforts.

The basic statutory authority for MCH is section 383.011, F.S. Administration of Maternal and Child Health Programs. The statute authorizes the FDOH to administer and provide MCH programs, including prenatal care programs, the Women, Infants and Children (WIC) program, and the Child Care Food Program. This statute also designates the FDOH to be the agency that receives the federal MCH and Preventive Health Services Block Grant funds.

Section 383.216, F.S., authorizes prenatal and infant coalitions for establishing partnerships among the private sector, the public sector, state government, local government, community alliances, and MCH providers and advocates, for coordinated community-based prenatal and infant health care. Chapter 64F-2, Florida Administrative Code, establishes rules governing coalition responsibilities and operations. Chapter 64F-3, FAC, establishes rules governing Healthy Start care coordination and services.

Section 383.014, F.S. authorizes screening and identification of all pregnant women entering prenatal care and all infants born in Florida, for conditions associated with poor pregnancy outcomes and increased risk of infant mortality and morbidity. This statute also governs screening for metabolic disorders and other hereditary and congenital disorders. Chapter 64C-7, Florida Administrative Code (FAC), establishes rules governing prenatal and infant screening for risk factors associated with poor outcomes, and rules related to metabolic, hereditary, and congenital disorders.

The basic statutory authority for CYSHCN and their families is Chapter 391, F.S., known as the Children's Medical Services Act. Section 391.016, F.S., establishes the Children’s Medical Services Program, and defines two primary functions: provide to children and youth with special health care needs a family-centered, comprehensive, and coordinated statewide managed system of care that links community-based health care with multidisciplinary, regional, and tertiary pediatric specialty care; and provide essential preventive, evaluative, and early intervention services for children at-risk for or having special health care needs, to prevent or reduce long-term disabilities. Section 391.026(13), F.S., is specific to the administration of the CYSHCN program in accordance with the Title V of the Social Security Act.

III.C. Needs Assessment
FY 2022 Application/FY 2020 Annual Report Update

The Maternal and Child Health Block Grant Needs Assessment is the guiding document for the MCH and CYSHCN programs. Partners and users of the needs assessment include county health departments, health districts, health planning organizations, health and social service organizations, federally qualified health centers, partner agencies, social service agencies, academic institutions, and numerous other organizations. Within the FDOH, it is used for improvement planning; agency strategic planning; workforce assessment planning; informing, educating and empowering residents about maternal and child health issues; and identifying research and innovation opportunities.

FDOH staff bears statutory responsibility for the ongoing monitoring of the needs assessment; however, the FDOH is only one part of the MCH and CYSHCN system. Efficient collaboration and coordination with other agencies, non-governmental organizations, institutions, and informal associations play an essential role in the needs assessment process.

Continual monitoring identifies priority health and quality of life issues and provides a focus for the organizations and entities that contribute to the MCH and CYSHCN system. Assessing strengths and weaknesses identifies the important health issues that are emerging or in need of potential new direction and may also identify additional health issues as perceived by residents and consumers. Lastly, continual monitoring and assessment determine forces that impact the way the MCH and CYSHCN system operates, including areas such as legislation, funding and funding shifts, and technology or other impending changes that may affect state residents, visitors, tourists or the system itself. These changes may provide opportunities for improvement and efficiency.

In 2020, Florida's overall infant mortality rate was 5.8 per 1,000 live births. The Healthy People 2030 target is 5.0 infant deaths per 1,000 live births. When the data are separated by race/ethnicity, the rate was 4.2 for White infants, 4.7 for Hispanic infants, and 10.7 for Black infants in the state. Statewide rates in 2020 were not statistically significantly different than rates in 2011. The FDOH is working to lower these rates through a variety of methods, including improving preconception health care and behaviors, safe infant sleep practices, breastfeeding practices, and smoking cessation rates among pregnant women, as well as strengthening relationships with community members and organizations.

MCH Indicators Dashboard

The MCH Section is often tasked with responding to requests from FDOH leadership and State Legislators for the most up-to-date quarterly data on fetal and infant mortality, birth rate, C-sections, and preterm births. A dashboard for each of these indicators will be updated monthly and quarterly and presented in tables containing results of statistical significance tests and data by county and state total. Aggregate data will be displayed in tables and graphs. Having an automated process for these inquiries would improve program efficiency.

Fetal and Infant Mortality Review (FIMR) Surveillance System Evaluation

An evaluation of the FIMR program began in July 2021. FIMR projects in the state of Florida are implemented by local Healthy Start Coalitions, and their individual practices and policies can vary between coalitions. The main goal of this evaluation is to identify areas in the FIMR process that would benefit from state-wide standardization, and improve the efficiency of infant mortality data collection, analysis, and dissemination. A key component of this evaluation is the input of FIMR team members on the efficiency of the FIMR process, which will be collected via an online survey. FIMR projects are comprised of two interdisciplinary teams: (1) the Case Review Team (CRT) and (2) the Community Action Team (CAT). The CRT, which consists of physicians, social workers, nurses, midwives, coroners, and mental health workers, ultimately drafts recommendations for community improvements based on case summaries. The CAT, which works to implement the recommendations of the CRT within the community via community education, program development, and existing program evaluation, is comprised of government representatives, health and human service organizations, and

passionate community members.

Florida Maternal Mortality Review Committee (Florida MMRC)

The FDOH continues to gather and publish data on pregnancy-related deaths. Florida MMRC, formerly known as the Pregnancy-Associated Mortality Review (PAMR), 2018 Report was finalized and is available on FDOH's website. The 2018 data update report provides an overview and comparisons of pregnancy-related death data and trends for Florida between the years 2008 and 2018.

Over the years, the Florida MMRC has produced four Urgent Maternal Mortality Messages (UMMM) aimed at providers. These UMMMs have been on hemorrhage-placental disorders, peripartum cardiomyopathy, maternal early warning systems for hospitals, and most recently opioid use during pregnancy. These messages were distributed to providers through Florida perinatal professional associations such as the District XII American College of Obstetricians and Gynecologists; Association of Women's Health, Obstetric and Neonatal Nurses, Association of Certified Nurse Midwives; and the Florida Perinatal Quality Collaborative. The work of the Florida MMRC drives the FDOH priority that all of Florida's mothers and infants receive high-quality, evidence-based perinatal care to help ensure the best health outcomes possible.

The Florida MMRC continues to use the Maternal Mortality Review Information Application (MMRIA) data system developed by the CDC. The MMRIA data system is designed to empower the maternal mortality review community to create action through a common data language and bring standardization to the maternal mortality review process across the nation. MMRIA is designed to support standardized case abstraction; case narrative development; documentation of committee deliberations on pregnancy relatedness, preventability and contributing factors; and routine analyses.

The Florida MMRC is also featured on the Association of Maternal and Child Health Programs (AMCHP) Review to Action website at: www.reviewtoaction.org, where Florida MMRC briefs and annual reports are available for viewing.

Children and Youth with Special Health Care Needs

In 2018, Children's Medical Services (CMS) was facing a challenge to transform from a direct-care service model to a public health assurance model. During our 2018 and 2019 projects, Children's Medical Services worked with the MCH Workforce Development center to strengthen the skills of our team, focusing on change management, systems-thinking, and appreciative inquiry. These skills were put to the test using various tools including the 5 Rs, logic model, and system support mapping in order to develop the framework for Florida's Regional Networks for Access and Quality (RNAQs). Three year follow up demonstrates that CMS has strengthened skills and abilities of teams and the number of Title V CYSHCN staff reporting that they could apply the skills they learned from the MCH workforce skill development training increased by 46 percentage points. CMS launched an additional 9 professional development opportunities, aligned with the public health core competencies in July 1, 2021 and developed a mentorship program, in which the pilot launch is anticipated in October 2021. As a result of the progress made, CMS was able to address this priority need and discontinue this previous state performance measure.

Annual Regional needs assessments inform strategic planning at both the community and state level for the CYSHCN program. As Florida's regions are very diverse, this process helps ensure sensitivity and early identification with emerging themes or needs as well as alignment with the current priorities. Results from the annual assessment process continued to support the priority needs of access to patient centered medical homes (PCMH), and access to behavioral/mental health treatment.

An estimated 4.2 million children and adolescents under the age of 17 reside in Florida. The National Survey of Children's Health for 2018-2019, indicates that approximately 47 percent of children and adolescents (ages 3-17 years) diagnosed with a behavioral/mental health condition do not receive the needed treatment. The afore-mentioned data is representative of children previously reported as screened and diagnosed, and was prior to the nation's pandemic, COVID-19. Many children

have yet to be screened for mental health disorders and may need care that has yet to be determined. Conclusions can be drawn that untreated behavioral and mental health conditions are pervasive across the state. Children are not receiving adequate services due to child and adolescent psychiatrist shortages, the maldistribution of providers, lack of behavioral health screenings, cultural barriers, stigma, and cost. As a result of COVID-19, evidence supports that depression and anxiety rates in children have doubled; further exacerbating the need for access to behavioral/mental health treatment.

The American Association of Child and Adolescent Psychiatry workforce map shows that there is a severe overall shortage of practicing child and adolescent psychiatrists in Florida, with only 412 practicing child and adolescent psychiatrists. This averages to 10 child and adolescent psychiatrists per 100,000 children. The child and adolescent psychiatrist shortage is not projected to improve significantly as the current workforce ages and not enough providers replace retirees. Long-standing evidence proposes behavioral health integration as key to combating mental health provider shortages.

Collective and intersectoral approaches occur across state and local organizations; however, there is no designated statewide network in place to communicate, learn, and participate in a quality improvement collaborative specific to behavioral health integration for children and adolescents. In response, CMS in in the early implementation stages with the establishment of a statewide network entitled the “Florida Pediatric Behavioral Health Collaborative” (FPBHC).

CMS is organized into seven geographic regions to address the large size and extreme variation in population density and available resources of our state. Employing national guidelines, academic medical university partners, also known as Behavioral Health Hubs (BHHS), partner locally with primary care practices and community mental health networks, with the goal of providing consultation and technical assistance in building the primary care providers capacity and skills to better identify and treat common behavioral health conditions in children. Starting with five regional academic medical university partners, child and adolescent psychiatrists provide regional training and consultation to primary care providers via telehealth and other modalities, thus building capacity in the primary care provider workforce. Each BHH works with community mental health experts, primary care providers, community partners and families and youth to collaborate in addressing the specific needs of their region based on local resources. BHHs have the autonomy to tailor integrated behavioral models based on their areas and readiness of local providers.

In response to the increased need for access to mental/behavioral health services, CMS applied to HRSA’s 2021 Pediatric Mental Health Care Access grant funding opportunity. The goal is to build two additional regional Behavioral Health Hubs (BHH), in needed underserved areas, to join Florida’s existing five BHHs and further fortify the FPBHC statewide network with representation in all of CMS’s seven geographic areas.

The statewide FPBHC is led by the CMS leadership team (Florida’s Title V CYSHCN Director and Bureau Chief/Director of Clinical Operations) and include representatives from state government agencies and organizations such as the Agency for Health Care Administration (AHCA), Medicaid program, Department of Children and Family’s Substance Abuse and Mental Health (DCF-SAMH) program, Florida Chapter of the National Alliance on Mental Illness (NAMI), and champions from the five existing BHH. As a statewide network, FPBHC will be responsible for organizing statewide communication and meetings, ensuring continuous quality improvement efforts and coordinating with state and community partners, especially through the technical assistance workgroup that operates like as Statewide Advisory Council.

The annual regional needs assessment process for CYSHCN, also identified asthma ER and hospitalization rates as a troubling trend. Leveraging the partnership with the FDOH’s Bureau of Chronic Disease Prevention led to the formation of a workgroup. As a result additional educational materials are in development, home visiting programs were utilized with expansion being planned, and a clinical pilot in a tertiary care center is underway.

Engaging with the two RNAQs has been an opportunity to work with one long standing partner in a new way, as well as establish new relationships with a complex clinic we had not previously worked with. The two teams are now currently collaborating through information sharing and developing a joint quality improvement project. In addition to the established RNAQs, a direct result of our teams’ strengthening system-building capabilities has resulted in the launch of Florida’s

Statewide Networks for Access and Quality (SNAQs). These SNAQs are condition-specific teams (e.g. Hematology/Oncology, Endocrine, HIV) that work locally to strengthen their local systems of care (using the National Standards for Systems of Care for Children and Youth with Special Health Care Needs) as well as work together on joint quality improvement projects through a Learning and Action Network (LAN) orchestrated by the National Institute for Children's Health Quality (NICHQ).

Family engagement and partnership, as part of health equity, continues to be a need including our SNAQ partners. Strategic planning includes the development of a how to or road map guide, with outlined steps and resources for systems to utilize in their implementation of family voice at all system levels. Family engagement and partnership will be a primary theme for this year's LAN. To provide partnerships across sectors to optimize maternal and child health populations, especially in the LAN environment, teams are looking at ways to work with people outside of the traditional health care system, mainly education right now.

The SNAQs (and other groups mentioned) have started to embrace population health approaches and better integration, and are thinking about and working on ways to better collaborate and communicate with PCPs with the goal of integrating primary care, specialty care, and public health. In order to develop evidenced-based and efficient health systems, CMS staff, the RNAQs, SNAQs and the other groups are all analyzing the data and working together to identify evidence-based or informed strategies in improving the care they deliver and the way children receive it.

Additional needs assessment findings has led to other recent or emerging partnership development to help improve the system of care for CYSHCN, including:

- Got Transition is working with Children's Medical Services and its vendor for the CMS Health Plan on a transition pilot
- A Dental/Orthodontia workgroup has been developed to help to address CYSHCN, access to services.
- A Pediatric Palliative Care Coalition to increase awareness of and access to palliative care in Florida
- Bullying prevention for CYSHCN

Emerging Public Health Issues

COVID-19 Pandemic

During earlier months of the COVID-19 pandemic, many places worldwide, including multiple U.S. states, began implementing stay-at-home orders and other policies to mitigate the spread of SARS-CoV-2. During this time, some investigators observed declines in preterm birth, yet others reported no change. Recognizing patterns in preterm birth rates within the United States during the pandemic may enhance understanding of the preterm birth etiology and guide programmatic strategies to reduce its incidence. We collaborated with 11 other states to examine preterm birth rates during the COVID-19 pandemic in 2020 compared with 2017–2019. We will conduct a more comprehensive analysis specific to Florida to examine rates of different birth outcome variables by various demographic, social, and clinical factors.

Furthermore, soon we will analyze Florida data from the Pregnancy Risk Assessment Monitoring System (PRAMS) COVID Supplement to gain a better understanding of how the COVID-19 pandemic has affect our maternal and child health population. The Florida PRAMS is a surveillance system of maternal behaviors and experiences before, during, and shortly after pregnancy. PRAMS survey responses can help improve resources, health care, and program services available to women and children across Florida. Supplemental questionnaires are added to the survey to address emerging topics, most recently COVID-19 infection. We will analyze this data to examine COVID-19-related delays in prenatal care and lack of social support, such as not being able to receive help with the baby and not having a partner or family member to accompany the mother to prenatal care visits or breastfeeding classes. Results will help identify potential strategies to improve the pregnancy experience and quality of health care and programs.

Out-of-Hospital Births

The popularity of out-of-hospital births in Florida has steadily grown for the past two decades, from a low of 0.87% of live births in 2001 to 1.77% in 2019. Provisional data indicates that in 2020, 2.04% of live births occurred out-of-hospital, a significant increase compared to the prior year. In August 2021, an in-depth surveillance report of planned out-of-hospital births in Florida began, examining maternal demographics, risk factors, and birth outcomes of these pregnancies. The goal of this report is to evaluate the changing landscape of women's healthcare, and improve access to quality healthcare before, during, and after pregnancy.

Opioid Crisis

While not emerging, the opioid crisis continues to be a major issue in Florida. Due to the overwhelming issue of opioid addiction and overdose deaths, goals were added to Florida's State Health Improvement Plan (SHIP) under the Behavioral Health Priority Area, which encompasses substance abuse. The FDOH, in partnership with the Florida Department of Children and Families (DCF) and other state agencies, established a priority area workgroup to collaborate on the goals and strategies of the priority area. To address the number of opioid overdose deaths among individuals with opioid use disorders, a campaign was implemented to increase access of naloxone to emergency departments, first responders, and law enforcement agencies, as well as to individuals at risk of witnessing or experiencing an opioid-related overdose.

Maternal Mortality

In 2021, the FDOH received an award notification from the Centers for Disease Control and Prevention (CDC) regarding the Preventing Maternal Deaths: Support Maternal Mortality Review Committees grant, to support agencies that coordinate and manage a maternal mortality review committee. The FDOH applied for the funding opportunity to strengthen the current Florida MMRC process. The grant will allow the Florida MMRC to enhance the current comprehensive case identification and review of pregnancy-related deaths and expand the ability to thoroughly review pregnancy-associated deaths, such as substance abuse and suicide cases. A pregnancy-associated death is a death to a woman from any cause, while she is pregnant or within one year of termination of the pregnancy, regardless of duration and site of the pregnancy. Pregnancy-related deaths are a subset of pregnancy-associated deaths. The Florida MMRC will also work with state and local partners to explore ways to address racial disparities in maternal deaths, create effective and actionable recommendations for care improvement, and convert those recommendations into actions.

Development of a State Health Improvement Plan Objective on Father/Partner Engagement

For Florida's upcoming 2022–2026 State Health Improvement Plan (SHIP), the state has been working to add a MCH objective focused on father or partner engagement during the perinatal period. Florida's SHIP stems from collaborative work of a diverse group of statewide partners to create a blueprint for action, under the leadership of the State Surgeon General. The SHIP sets goals for Florida's public health system, including state and local government agencies, health care providers, employers, community groups, universities and schools, non-profit organizations, and advocacy groups. We conducted a literature review and summarized interventions that sought to improve partner involvement during pregnancy. Results from this review will guide Florida on selecting an appropriate evidence-based objective for the 2022–2026 SHIP cycle.

Development of a Safe Infant Sleep & Breastfeeding Event Planning Toolkit for African American Sororities and Fraternities

African American infants are at a higher risk of dying than other racial and ethnic groups in the United States. Two ways to prevent infant deaths are practicing safe infant sleep and breastfeeding. To increase safe infant sleep and breastfeeding, community events can be used as tools to inform African American communities by trusted individuals. African American Greek Organizations or Fraternities and Sororities, as trusted community members, can play an important role in decreasing infant sleep practices that are not safe and increasing breastfeeding initiation and duration in areas of Florida that need the most help. By using this toolkit, African American Greek Organizations can join in the ongoing effort to save babies from dying of preventable causes and help eliminate racial disparities. We will meet with representatives of these

organizations again to obtain feedback on our drafted toolkit.

Literature Review: Long-Acting Reversible Contraception (LARC) Interventions Across the Social Ecological Model (SEM)

With support from two students from the Title V Internship Program, we conducted a literature review of interventions that sought to increase use of LARC methods, namely intrauterine devices and implants. LARC methods safely prevent unintended pregnancies and short interpregnancy intervals, which increase the risk of adverse birth outcomes. We applied the SEM perspective, a framework for improving health that considers individual, interpersonal, organizational, community, and policy levels of influence to identify patterns of effectiveness across the SEM. We summarize findings from interventions that sought to increase LARC use and map interventions to SEM levels. In addition to sharing findings with key MCH partners in the state, we will submit a paper for publication.

Medicaid Data Analysis on Postpartum Contraceptive Use

With support from the Graduate Student Epidemiology Program, funded by the Health Resources and Services Administration, we analyzed Medicaid data provided by Florida's Agency for Health Care Administration to examine postpartum contraceptive use among Women on Medicaid from 2016 through 2020. We examined patterns of effective contraception, including LARC use, among postpartum women with Medicaid insurance in two age groups (15-20 and 21-44) at 3 and 60 days postpartum after linking eligibility, claims, and encounter Medicaid data. We also explored the patterns of postpartum contraception use by age group, race/ethnicity, poverty status, refugee status, delivery type, and Medicaid type.

Index of Concentration at the Extremes (ICE) and Preterm Birth Analysis

In collaboration with experts from federal and academic institutions, we are examining ICE as a risk factor of preterm birth subtypes. ICE is a promising measure of spatial polarization that can simultaneously capture extremes of privilege and deprivation as well as economic and racial/ethnic segregation. Identifying differences between spontaneous and medically-indicated preterm birth or live births <34 or 34-36 weeks gestation may guide Florida public health and clinical interventions on how to strategically focus resources on groups most affected by racial and economic disparities.

The FDOH is operationalizing a health equity framework into all program and policy work beginning with the needs assessment process and findings, and culminating into the State Health Improvement Plan (SHIP) and Agency Strategic Plan. The framework includes:

- Improving the accessibility of the health system through outreach, location, physical design, opening hours, and other policies.
- Improving the patient-centeredness of the system by providing culturally competent care, interpretation services, and assisting patients and families who face social and economic barriers to care.
- Partnering with other sectors to improve population health.

The block grant outlines innovations and opportunities for operationalizing each of these aspects of health equity to advance on and improve our needs assessment findings. Furthermore, in partnership with members of our SHIP MCH Workgroup, we established a formal process for assessing MCH programs and policies from a health equity perspective.

Following are some changes since last year's application in the Department's leadership positions that provides oversight to Title V:

Shay Chapman, BSN, MBA was named Deputy Division Director for Community Health Promotion in March 2021. Prior to her new role, Shay served as the Bureau Chief for Family Health Services.

Cassandra Pasley, BSN, JD was appointed as Chief of Staff. Prior to her appointment, she served as the Division Director

for Medical Quality Assurance.

Five-Year Needs Assessment Summary
(as submitted with the FY 2021 Application/FY 2019 Annual Report)

III.C.2.a. Process Description

Since 2010, the Department has completed a more data-driven Title V Needs Assessment (NA). Our stakeholder and capacity surveys were quantitative tools used to help identify performance measures and develop five-year work plans. A major emphasis was placed on coordinating the selected priorities with the Department's State Health Improvement Plan (SHIP), Agency Strategic Plan, the Collaborative Improvement and Innovation Network (CoIIN) priorities, and the partners engaged in the activities addressing the priorities. The intent was to focus efforts across the Department and state for collective impact. A comprehensive explanation of the Maternal and Child Health (MCH) Section's NA can be found as an attachment, with a brief overview below.

As the MCH Section began the 2020 Five-Year NA process, an internal advisory workgroup and a statewide advisory workgroup were established. The internal workgroup included staff from sections and divisions across the Department. The statewide advisory workgroup consisted of Department staff and various partners throughout the state, including local health departments, Healthy Start Coalitions, local advocacy organizations, and university partners.

A public input survey was disseminated to obtain feedback from stakeholders and the public on how to prioritize MCH and Children and Youth with Special Health Care Needs (CYSHCN) matters in Florida. A total of 404 responses were received. A second survey was sent to assess Florida's capacity to carry out the 10 essential services of maternal and child health. This survey was distributed to 43 MCH partner organizations in Florida, of which 24 responded.

Finally, a Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis was conducted of priority topics using the Capacity Assessment for State Title V tool. The statewide advisory workgroup recommended that Florida should keep the priority areas and corresponding national and state performance measures from the previous five-year NA. The advisory group also recommended the state give serious consideration to the following three performance measures: (1) risk appropriate perinatal care, (2) adequate insurance, and (3) adolescent physical activity.

Recognizing there is still work to do on many of the priorities identified from the 2015 NA the Florida Department of Health decided to (1) continue working on the National Performance Measures (NPMs) and State Performance Measures (SPMs) selected in 2015 and (2) add risk appropriate perinatal care and adolescent physical activity to our final list of 2020 MCH priorities given the results from the general input survey and CAST-V process as well as recommendations from the Title V state advisory workgroup.

The Office of Children's Medical Services Managed Care Plan and Specialty Programs (CMS) underwent a multi-phase NA process, specific to the CYSHCN Domain. Keeping in line with the overarching goal of improving the system of care that serves CYSHCN, guiding principles from the *National Standards for Systems of Care for CYSHCN, the Title V Maternal & Child Health (MCH) Pyramid of Health Services, and the Public Health Pyramid of Prevention* served as the underpinnings of this process. While the NA phases themselves, aligned with the *State MCH Block Grant Needs Assessment, Planning, Implementation, and Monitoring Process* Framework, coined by the Federal MCH Bureau. These phases included: (1) assessing needs; (2) examining strengths and capacity; (3) priority selection; and (4) setting performance objectives and development of a five-year action plan to achieve these aims. To ensure goals were achieved and tasks were tracked and fulfilled, a Gantt chart was constructed and sustained throughout the process.

To foster objective and inclusive progression, stakeholder engagement (including families, field experts, and Department leadership/staff) and mixed data collection practices were critical components of the NA process. In addition to analyzing secondary data sources like the *National Survey of Children's Health* and *Florida Charts*, surveys and focus groups were quantitative and qualitative methodologies utilized to comprehensively inform the process.

To adequately assess needs, strengths, and be intentional about stakeholder voice, caregivers of CYSHCN and young adults that identified as having special needs were asked to participate in primary data collection processes. A total of 247 parent/caregiver and 65 young adult questionnaires were administered. Additionally, over 75 participants, inclusive of

caregivers, providers, and champions, participated in nine focus groups and key informant interviews-conducted virtually and face-to-face across the State of Florida.

Also, a CYSHCN NA statewide workgroup was formed and met monthly to provide their knowledge base and advisement throughout the NA process. Representation for this group was extensive and included leadership from CMS, Florida Health and Transition Services, Florida Family Leaders Network, University of South Florida College of Public Health, Family Network on Disabilities, Leadership Development in Neurodevelopmental Disabilities (LEND) training program, Broward Health Specialty Program, National Alliance on Mental Illness, Department of Children and Families, Agency for Health Care Administration, Florida Healthy Kids, Florida Chapter of American Academy Pediatrics, Florida Association of Children's Hospitals, Florida Military Family Special Needs Network, and other key players. Eleven potential priority areas (mental health, family partnership, medical home, early screening, adequate insurance, access to care, adult transition, obesity, suicide, health promotion, and workforce development) were determined with the assistance of the aforementioned stakeholders and procedures.

To evaluate strengths and capacity, workgroups, comprised of internal CMS staff and family support specialists, were assembled to undertake the CAST-V Process. These groups added their area of expertise, reviewed issue briefs (outlined the issue, trend data, national/state goals, current initiatives, evidence-based practices and capacity), conducted SWOT analyses, which were converted into an appreciative inquiry approach using strengths, opportunities, aspirations and results (SOAR), and completed capacity worksheets (have or need certain structural resources, data/information systems, organization relationships, and competencies) for each of the 11 potential priority areas.

During the priority selection phase, a NA Scoring Team, including lived family experience, was provided the CAST-5 materials and a scoring tool, for ranking the 11 potential priorities. Medical home and mental/behavioral health were identified as the priority areas for the CYSHCN domain. The above-mentioned approaches resulted in two action planning workgroups launching with the role of thinking collaboratively, to develop priority specific performance objectives, strategies, and activities. Participants were CMS staff and external partners like volunteers from the statewide workgroup, physicians, and CYSHCN experts, including family leaders. Many of those emergent themes from the focus groups were included in the action plans. Action plans also integrated the following priority-inclusion areas: Transition, Family partnership, Health Equity, Workforce Development, Life Course/Cross-Cutting and leveraging core Public Health functions, these inclusion areas were embedded within various activities of the plans.

III.C.2.b. Findings

III.C.2.b.i. MCH Population Health Status

Women/Maternal Health

Several indicators provide insight into the health of women, pregnant women, mothers, and infants as they relate to Women/Maternal Health and Perinatal/Infant Health domains. The most recent Pregnancy Risk Assessment Monitoring System (PRAMS) Report provides insight into the health and behaviors of women in Florida. A total of 28.8 percent of women were dieting before pregnancy and 44.2 percent were exercising three or more days a week. PRAMS showed 16.8 percent of women used prescription medications before pregnancy, 8.8 percent were being checked/treated for diabetes, 10.4 percent were checked for high blood pressure, 9.7 percent were checked/treated for depression/anxiety, and 25.3 percent had discussions about family medical history with a health care worker before pregnancy. A total of 33.7 percent of new moms reported they were uninsured before pregnancy, and 58.1 percent participated in WIC. A total of 21.4 percent of women reported smoking cigarettes before pregnancy, while 8.6 percent smoked during pregnancy. A total of 51.2 percent of women reported that they drank alcohol before pregnancy, while 7.9 percent drank during pregnancy.

Racial disparity is evident in pregnancy related mortality ratio (PRMR). From 2008-2018, the Florida Pregnancy Associated Mortality Review (PAMR) classified 408 cases as pregnancy-related deaths (PRDs). During this period, the pregnancy related mortality ratios for non-Hispanic black women were significantly higher compared with non-Hispanic white and Hispanic women. For example, in 2018 the PRMR per 1,000 live births was 32.0 for non-Hispanic black women, 12.9 for non-Hispanic white women, and 10.6 for Hispanic women.

Three goals of the Department are: reduce the rate of maternal deaths per 100,000 live births from 16.3 to 16.0; increase from 17 percent to 21 percent women having a live birth who received preconception counseling about healthy lifestyle behaviors and prevention strategies from a health care practitioner prior to pregnancy; and increase from 76 percent to 84.5 percent of pregnant women receiving prenatal care during the first trimester.

The Department is funding interconception care (ICC) and early entry into prenatal care through Florida's Healthy Start program. ICC is provided to a woman who has previously been pregnant and has risk factors that may lead to a future poor pregnancy outcome or a mother who is receiving services on behalf of her Healthy Start infant. Healthy Start Coalitions are responsible for assisting a pregnant woman with obtaining early access to prenatal care to mitigate risk factors and improve outcomes for mother and baby.

Perinatal/Infant Health

In Florida, infant mortality rates (IMR) have declined slightly from 6.2 infant deaths per 1,000 live births in 2015 to 6.0 infant deaths per 1,000 live births in 2019. Non-Hispanic white infant mortality has remained relatively flat with an IMR of 4.9 infant deaths per 1,000 live births in 2009 and 5.0 infant deaths per 1,000 live births in 2013. Between 2015 and 2019, non- Hispanic black IMR declined significantly from 11.0 to a low of 10.4 infant deaths per 1,000 live births. With Florida's recent declines in non-Hispanic black infant mortality, the infant mortality disparity between non-Hispanic black and non-Hispanic white infants have decreased from a ratio of 2.6:1 in 2015 to 2.4:1 in 2019. It is important to note that despite this decline in the magnitude of disparity, non-Hispanic black IMR has consistently remained more than two times higher than non-Hispanic white and Hispanic IMR.

During the same period, the neonatal mortality rate declined from 4.4 per 1,000 live births to 4.2 per 1,000 live births. The post-neonatal mortality rate declined from 1.9 per 1,000 live births to 1.8 per 1,000 live births.

The Department is addressing black-white disparities in infant mortality by providing and facilitating preconception care and counseling, prenatal care, infant health services, ICC and counseling, and other preventive health services. The Department, MCH practitioners, and community partners realize confronting inequities in health care access, interventions and outcomes requires examining care systems, individual risk factors, community resources and deficit and cultural factors that interact to influence and/or determine health outcomes, including infant mortality.

Florida Healthy Start Coalitions conduct planning and service delivery approaches that incorporate Florida communities as partners and participants in disparity elimination. To help reduce infant mortality, Florida has established safe infant sleep as a priority in the State Health Improvement Plan with the following objectives related to infant sleep position and bed-sharing: (1) By December 31, 2021, reduce percent of black mothers in Florida whose infant sleeps in bed with a parent or anyone else from 26.4% (2014) to 24.8%. (2) By December 31, 2021, increase percent of black mothers in Florida who placed their infant on their back to sleep from 56.4% (2014) to 58.4%.

According to the 2015 Florida PRAMS data, 73.3 percent of infants were placed to sleep on their backs and 77.8 percent never bed-shared. For non-Hispanic black infants, 2015 percentages were worse for both back-sleeping (57.8 percent) and never bed-sharing (68.5 percent) compared to state and national data, overall and specific to the non-Hispanic black infant population. These, Florida safe sleep statistics are comparable with overall national data.

In 2019, 78.9 percent (2,737 out of 3,469) of Very Low Birth Weight (VLBW) infants in Florida were delivered at facilities for high-risk deliveries and neonates, an increase from 75.8 percent (2,652 out of 3,497) in 2015. No clear or consistent racial/ethnic disparities were observed.

The Department provides statewide access to high-risk perinatal care through 11 designated Regional Perinatal Intensive Care Centers (RPICCs) and two obstetrical satellite clinics. RPICCs provide perinatal intensive care services that contribute to the well-being and development of a healthy society. This regionalized network of hospitals also includes obstetrical care for high-risk pregnant women at obstetrical satellite clinics in rural areas.

Through community and provider education, the RPICCs increase awareness of services provided, which enhances accessibility to appropriate levels of care. Many RPICCs also participate in the Florida Perinatal Quality Collaborative (FPQC), a collective of perinatal-related organizations, individuals, health professionals, advocates, policymakers, hospitals and payers. RPICCs also provide staffing for the emergency medical transportation of high-risk pregnant women and sick or low birth weight newborns from outlying hospitals to the appropriate level facility for care.

The Department will continue to support services to increase the percentage of VLBW infants who deliver and receive care at hospitals with Level III neonatal intensive care units (NICUs). Plans include the continuation of high-risk obstetrical satellite clinics, continued encouragement of participation in the FPQC by designated RPICC staff, and the continuation of the designated RPICCs. The Department will continue to monitor the RPICCs to ensure appropriate placement of neonates in the Level III NICUs.

Child Health and Adolescent Health

Each year in Florida, one in 10 children (ages 19 and younger) are injured seriously enough to require a visit to the emergency room or admission to the hospital. While statewide unintentional injury rates remained steady in recent years, Florida's age-adjusted injury death rates are higher than the national average. In 2011, Florida's age-adjusted injury death rate for all unintentional injuries (41.8 per 100,000) was higher than the national average (39.0 per 100,000) by 7.2 percent. Among children, the trend worsens. Florida's age-specific injury death rate for unintentional drowning among children ages 1-4 was 7.2 per 100,000, and was 166.7 percent higher than the national average of 2.7 per 100,000. Racial/ethnic disparities exist such that unintentional injury rates are substantially higher among non-Hispanic black children than among non-Hispanic white and Hispanic children.

Safe Kids Florida, led by the Department's Injury Prevention Program, uses local coalitions to provide and promote leadership to reduce unintentional childhood injury and death. Safe Kids Florida works to reduce unintentional injury and death by promoting community awareness and education, supporting public policies and programs that reduce injury, and providing safety education on various risk areas including traffic and water safety. Currently, there are 13 Safe Kids coalitions across the state covering 81 percent of Florida's 19 and under population.

Florida leads the country in drowning deaths of children ages 1-4. In 2011, the Injury Prevention Program launched the *Waterproof FL: Pool Safety is Everyone's Responsibility* initiative. This campaign, focusing on early childhood drowning prevention, identifies supervision, barriers, and emergency preparedness as three layers to increase pool safety. The WaterproofFL website (http://www.floridahealth.gov/alternatesites/waterprooffl/) offers an online toolkit for partners, advocates, and parents across the state. Since the program was launched, the age-adjusted drowning rate has dropped from 1.82 per 100,000 in 2011, to 1.79 per 100,000 in 2012, and to 1.77 per 100,000 in 2013.

The adolescent age group has lower well care visit rates compared to adults and young children. These rates likely reflect the challenges of reaching and engaging adolescents in preventive and primary health care. In 2011-2012, the prevalence of children ages 12-17 with no preventative medical care visits during the past 12 months was 19.8 percent in Florida and 18.2 percent in the nation. According to 2011-2012 data from the National Survey of Children's Health, no significant racial/ethnic disparities existed among children younger than 18 regarding preventative medical care visits.

In 2013, Florida male public high school students (34.1 percent) had a significantly higher prevalence of meeting the current federal physical guidelines for aerobic physical activity than females (16.4 percent). Non-Hispanic (NH) white (28.0 percent) public high school students had a significantly higher prevalence of this behavior than NH black (23.6 percent) and Hispanic 21.3 percent) public high school students.

According to the Behavioral Risk Factor Surveillance System (BRFSS), 65.9 percent of Florida residents age 18 and older were overweight or obese in 2018. This percentage ranked Florida 23rd in the nation. The Department has many initiatives and programs in place to increase physical activity among children and adolescents. Ongoing projects include working with early childhood education centers and schools to develop and implement policies relating to physical activity of the

children and adolescents while they are in the centers/schools. Programs such as the Alliance for a Healthier Generation's Healthy Schools Program and the Healthier United States Schools Challenge emphasize the importance of incorporating physical activity into the school day and teaching children and their parents about the importance of physical activity.

Children with Special Health Care Needs

The literature tells us that a patient centered medical home (PCMH) is of importance to children with special health care needs. Data from the 2009-2010 National Survey of Children with Special Health Care Needs (CSHCN) shows that 36.2 percent of children in Florida have a PCMH, compared to 43 percent nationally. The survey data also shows that 37 percent of Florida's CSHCN are receiving appropriate transition services, compared to 40 percent nationally. Transition services are vital to children and youth with special health care needs as it improves lifelong functioning and well-being. In addition to medical home and transition being top priorities for Florida, mental health was also identified through the needs assessment to be of extreme importance. The CDC estimates that one in five children under age 18 has a diagnosable mental health disorder and one in 10 youths have a serious mental health problem that is severe enough to impair their function; yet four out of five children who need mental health services do not receive them.

Other Findings/Strengths/Needs

Maternal deaths are increasing in Florida. From 2001–2003 there were 63 maternal deaths (ratio: 10.1 per 100,000 live births). From 2016–2018 there were 100 maternal deaths (ratio: 14.9 per 100,000 live births). In 2017, Florida PAMR began the transition to implementing the new Maternal Mortality Review Information Application (MMRIA). MMRIA is an electronic data system designed to support standardized data collection and help Maternal Mortality Review committees organize available data and begin the critical steps necessary to comprehensively identify, access, and abstract cases.

During state FY 2013-2014, the Public Health Dental Program implemented a statewide oral health surveillance system to collect data on specific oral health indicators to provide information about unmet dental needs, workforce deficiencies, access to care barriers, and populations at risk for poor oral health outcomes. Specific goals of the surveillance system include: monitor the status of high risk populations; identify unmet dental needs and barriers to care for disparate populations; assess workforce shortages and the distribution of Medicaid providers; and develop policies and programs to address barriers to care and service limitation. In 2016-2017 school year, the second Florida Third Grade Oral Health Surveillance Survey was conducted. The surveillance survey was conducted in a representative sample of schools screening over 1,200 third-grade students for evidence of caries experience, untreated decay, and presence of dental sealants. This data indicated that 25.1 percent had untreated caries, 45.5 percent had the presence of either untreated or treated (restored or filled) tooth decay, 40.5 percent had sealants present, three percent needed urgent care, and 20.6 percent needed early dental care. The Program completed its second Head Start Surveillance Project during the 2017-2018 school year. Preliminary data indicates 24 percent of Head Start children had untreated decay and 34.3 percent had caries experience.

Through the issue briefs and SWOT analyses, current efforts for the CSHCN population were examined for each priority need. Through the Children's Health Insurance Reauthorization Program Act (CHIPRA) grant project, Florida identified medical home strategies that worked well in several Florida locations. Florida's CHIPRA report will be utilized to determine what strategies should be encouraged as well as utilizing other recognized tool kits. CMS has implemented care coordination guidelines and performance standards that outline transition education standards for CMS care coordinators to follow. Further education and training across professions needs to occur to raise awareness about the importance of transition activities.

III.C.2.b.ii. Title V Program Capacity

III.C.2.b.ii.a. Organizational Structure

The Department is directed by the State Surgeon General, Secretary of Health, who is appointed by and directly reports to the Governor. The Surgeon General is responsible for overall leadership and policy direction of the Department. The

Surgeon General is assisted by the following key staff:

Chief of Staff: oversees the offices of Communications and Legislative Planning

Deputy Secretary for Operations: oversees many of the Department's key support functions including the Office of Budget and Revenue Management, Division of Administration, which includes the Bureaus of Finance and Accounting, General Services, and Personnel and Human Resource Management; the Division of Disability Determination; the Office of Information Technology; and the Division of Medical Quality Assurance.

Deputy Secretary for County Health Systems: provides oversight and direction to the state's 67 local health department directors/administrators.

Deputy Secretary for Health: provides oversight to the divisions of Public Health Statistics and Performance Management; Emergency Preparedness and Community Support, Community Health Promotion, Disease Control and Health Protection, the Office of Minority Health and Health Equity and the Office of Medical Marijuana use.

Deputy State Health Officer for Children's Medical Services: oversees the division of Children's Medical Services and 22 CMS Regional/Area Offices.

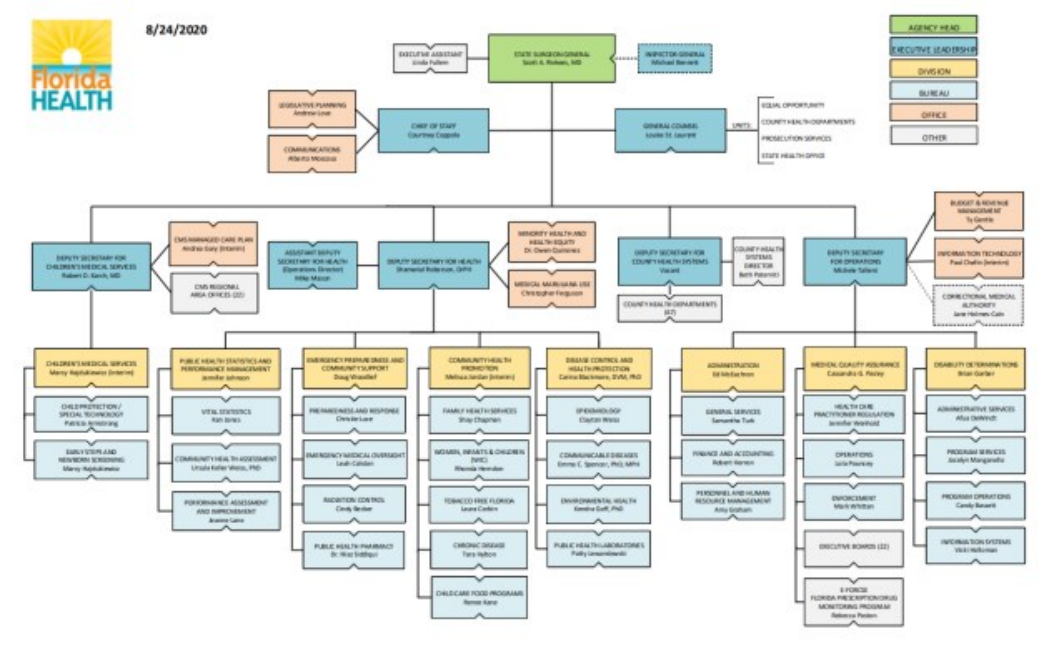
The Department is responsible for the administration of programs carried out with allotments under Title V, as authorized under Section 383.011(1)(f), Florida Statutes. Many of these programs fall within the auspices of the Division of Community Health Promotion and the Division of Children's Medical Services. The Title V Maternal and Child Health and Children with Special Health Care Needs programs are located within these divisions. Shay Chapman, BSN, MBA, Chief of the Bureau of Family Health Services, serves as the Title V MCH Director. Robert Karch, M.D. was named as Deputy Secretary for Children's Medical Services in March 2020. Jeffrey P. Brosco, MD, PhD, in a physician consultant role with the Department, continues as the Title V CYSHCN Director.

The Division Director of Community Health Promotion provides leadership, policy, and procedural direction for the Division, which includes the Bureaus of Child Care Food Programs, Chronic Disease Prevention, Family Health Services, Tobacco Free Florida, and WIC Program Services.

The Bureau of Family Health Services is responsible for many of the Title V activities related to pregnant women, mothers, infants, and children. The Bureau Chief provides oversight and direction for the Public Health Dental Program; Violence and Injury Prevention Section; the Maternal and Child Health Section; and the School Health Services Section and the Adolescent and Reproductive Health Section.

The MCH Section includes the Healthy Start Program; the MCH Program which has, among other responsibilities, Pregnancy Associated Mortality Review and Fetal and Infant Mortality Review; and the Grants/Data/Budget/Procurement unit, which has primary responsibility for coordinating and collating information for the Title V MCH Block Grant application.

Below is the organizational table for the Florida Department of Health. The table is also included as an attachment.



III.C.2.b.ii.b. Agency Capacity

Children's Medical Services is charged to administer the Children with Special Health Care Needs program in accordance with Title V of the Social Security Act. Additionally, CMS is responsible for providing CYSHCN a family-centered, comprehensive, and coordinated statewide managed system of care that links community-based health care with multidisciplinary, regional, and tertiary pediatric specialty care. This is in line with Florida's Department of Health mission to protect, promote and improve the health of all people in Florida through integrated state, county, and community efforts.

CMS is also able to serve CYSHCN as an optional specialty plan through the Statewide Medicaid Managed Care (SMMC) Managed Medical Assistance (MMA) Program for CYSHCN who meet clinical eligibility criteria.

Florida KidCare is Florida's Children Health Insurance Program (CHIP) and has four partner agencies: Medicaid, DCF, CMS, and Florida Healthy Kids Corporation. CMS is an option for children who meet clinical eligibility criteria. The Florida KidCare Coordinating Council reviews and makes recommendations concerning the implementation and operation of the Florida KidCare program. Council membership includes representatives from the Department, DCF, the AHCA, the Florida Healthy Kids Corporation, the Department of Insurance, local governments, health insurance companies, health maintenance organizations, health care providers, families participating in the program, and organizations representing low-income families.

The CMS Safety Net Program serves CYSHCN from birth to 21 years of age who do not qualify for Medicaid or Title XXI, but who are unable to access, due to lack of providers or lack of financial resources, specialized services that are medically necessary or essential family support services. Families are required to contribute financially in the cost of care based on a sliding fee scale. The CMS Safety Net Program is not health insurance. The program provides a limited health services package for the enrollee's primary and secondary qualifying conditions, selected by the parent or legal guardian, and are provided based on the availability of funds. All services require prior authorization.

Infants identified through the Newborn Screening Program with a positive screen may also receive confirmatory testing through CMS, as a payer of last resort, if needed.

Early Steps is Florida's early intervention system that offers services to eligible infants and toddlers, birth to 36 months, with significant delays or a condition likely to result in a developmental delay. Early intervention is provided to support

families and caregivers in developing the competence and confidence to help their child's development. Early Steps uses a Team Based Primary Service Provider approach that aims to empower each eligible family by providing a comprehensive team of professionals from the beginning of services through transition. The goal is for families to receive strong support from one person, provide a comprehensive team of professionals from beginning to end, and for the family to have fewer appointments and more time to be a "family." Services are provided to the family and child where they live, learn, and play, to enable the family to implement developmentally appropriate learning opportunities during everyday activities and routines. There are 15 Early Steps offices in Florida.

CMS also works closely with Florida's university systems, hospitals, hospices, pediatricians, and specialists through established statewide programs to ensure quality health care services are provided to children with special health care needs. These programs include the CMS Cardiac Program; the CMS Craniofacial, Cleft Lip/ Cleft Palate Program; the Comprehensive Children's Kidney Failure Centers Program; the CMS Hematology/Oncology Program; the CMS HIV Program; the Partners in Care: Together for Kids Program, Florida's Pediatric Program for All Inclusive Care; and the RPICC Program.

As part of the objectives of the Title V MCH Program, the Public Health Dental Program (PHDP) continues to collaborate with other state agencies and not-for-profit organizations to plan and implement programs that address the oral health needs of children and families. The PHDP continues to help implement and develop a state oral health action plan with the AHCA to increase the number of children who receive dental services through Medicaid and CHIP programs. Policy development for the Medicaid State Action Plan includes; revising billing codes and dental services to expand coverage for preventive services, such as dental sealants and fluoride varnish, and the integration of dental care with medical and behavioral health care provided through medical managed care plans to assist families in identifying a medical/dental home for services.

The PHDP also participates in dental health initiatives planned by the Oral Health Florida, Inc. coalition. This organization is comprised of a wide group of individuals and agencies that work in partnership to address their mission to promote and advocate for optimal oral health and well-being of all persons in Florida. The PHDP works with the coalition on several initiatives to increase oral health services for children and families in Florida.

Through the support of funding from the MCHBG and in collaboration and partnership with the Florida Dental Hygienists' Association, the Association of State and Territorial Dental Directors, various primary schools and Head Start Centers throughout the state, the PHDP conducted Third Grade and Head Start Oral Health Surveillance Projects. These projects are important for identifying the unmet dental needs of children and for assisting high risk families with establishing a dental home and identifying local resources for continuing dental care. The Third Grade Oral Health Surveillance Project was completed in 2017 and the results were posted in 2018. The Head Start Surveillance Project was completed in 2018 and results will be posted in the Fall of 2020.

The PHDP, in conjunction with the Oral Health Florida Sealant Action Team, continues to promote the use of a cost-efficient dental hygienist workforce model for School-based Sealant Program service delivery. The local health department dental programs, Federally Qualified Health Centers, and local oral health coalitions across the state provide preventive services to children in Title I schools, Head Start, Early Head Start and Early Learning Centers and Women Infant and Children (WIC) sites. Providing these services to the children in school settings eliminates many barriers that impact access to dental care. School-based sealant programs are supported by MCHBG funding making it possible to reach high risk children in need of dental services and to improve dental outcomes for all children in the state.

During the state fiscal year (SFY) 2018-2019, school-based sealant programs provided services across 48 counties in Florida.

Dental sealant programs served over 1,250 schools, Early Head Start Centers, Head Start Centers, Early Learning Centers and WIC sites resulting in 146,535 children served. This resulted in the following services provided: 240,747 sealants, 35,320 cleanings and 136,983 fluoride varnish applications. In the first year of this initiative (SFY 2014-2015) three local health department programs developed and implemented a school-based sealant program with the support of MCHBG. Since 2014-2015, 37 local health department programs have received funding to initiate or expand school-based sealant

programs. Currently, in SFY 2020-2021 eight school-based sealant programs received funding. At the time of this application, 50 out of the 67 Florida counties operate a school-based sealant program, many in part, due to MCHBG funding support for the start-up and expansion costs of programs.

CMS works closely with several sister agencies, including AHCA, DCF, the Agency for Persons with Disabilities, the Department of Education, Florida's Office of Early Learning, the Guardian Ad Litem Program, and the Department of Juvenile Justice to ensure services are delivered through a seamless, coordinated system. CMS also works with the Family Network on Disabilities and the Family Café to educate families about engaging in health care decisions. Additionally, CMS works closely with the Florida Health and Transition Services (FloridaHATS) to educate and promote awareness related to health care transition. Additional partners of CMS working to improve the quality of care and outcomes for children with special health care needs include Florida Hospices, Florida School for the Deaf and Blind, Easter Seals, Centers for Autism and Related Disorders, and the Florida Developmental Disabilities Council.

III.C.2.b.ii.c. MCH Workforce Capacity

At the Florida Department of Health Central Office, there are 20 full-time staff within the Maternal and Child Health Section. Title V provides funding for 17 of those positions. Within the Adolescent, and Reproductive Health Section, there are 13 positions, one is funded by Title V. There are 11 positions within the Public Health Dental Program, one of which is funded by Title V. Statewide, there are approximately 2,900 Department staff working in positions directly related to Title V.

In Children's Medical Services, there are a total of 710 full-time positions. Of that total, 679 are within the Children's Medical Services Managed Care Plan, 12 are with the Child Protection Teams, 12 are with the Newborn Screening Program, and seven are with the Early Steps Program. None of these positions are funded with Title V funds.

Executive level and senior level management employees who support MCH activities and program staff who contribute to the state's program and health policy planning, evaluation, and data analysis capabilities include the following:

Scott Rivkees, MD, was appointed by Governor DeSantis as Florida State Surgeon General and Secretary of Health in April 2019. Before his tenure as Florida's Surgeon General, Dr. Rivkees served as chair of the department of pediatrics at the University of Florida College of Medicine and physician-in-chief of UF Health Shands Children's Hospital, part of UF Health Shands Hospital and the University of Florida's Academic Health Center. He also served as academic chair of pediatrics at Orlando Health and the University of Florida College of Medicine pediatric chair at Studer Family Children's Hospital at Sacred Heart in Pensacola.

Shamarial Roberson, DrPH, MPH, was appointed as the Deputy Secretary for Health in Fall 2019. Dr. Roberson most recently served as the Department's Director for the Division of Community Health Promotion.

Robert D. Karch, MD was appointed as the Deputy Secretary for Children's Medical Services in Fall 2019. Dr. Karch joined The Nemours Foundation in 2011. He served as the President of the Medical Staff at Nemours Children's Hospital and as the Chairman of the Medical Executive Committee. Dr. Karch is board certified by the American Board of Pediatrics and the American Board of Physician Nutrition Specialists and is a fellow of the American Academy of Pediatrics.

Melissa Jordan, MS, MPH, is the Director of the Division of Community Health Promotion, which includes the Bureaus of Child Care Food Programs, Chronic Disease Prevention, Tobacco Free Florida, Family Health Services, and WIC Program Services. Ms. Jordan also serves as the Director of the Office of Public Health Research.

Shay Chapman, BSN, MBA, serves as the Chief for the Bureau of Family Health Services, under which the Title V programs are located, and is the Title V MCH Director in Florida.

Anna Simmons, MSW, joined the MCH Section in 2013 and was promoted to her current position as Section Administrator in December of 2019. Ms. Simmons has spent her time at the Department in the Maternal and Child Health section.

Andrea Gary currently serves as the Interim Director for the Office of Children's Medical Services Managed Care Plan and

Specialty Programs, previously having served as the Bureau Chief for Administration under the Office. Ms. Gary joined the department in 2015, her expertise includes 14 years in state government with a background in business and communications.
Jeffery Brosco, MD PhD, previous Deputy Secretary for CMS, continues to serve in a contracted position as the Title V CYSHCN Director. Dr. Brosco completed his MD and a PhD at the University of Pennsylvania, he is board-certified in Pediatrics and in Developmental-Behavioral Pediatrics. He continues to teach and practice medicine at the University of Miami; his research focuses on ethics and health policy. Dr. Brosco is active in state and national health policy groups, including the National Workgroup on Standards for Systems of Care for Children and Youth with Special Health Care Needs (Association of Maternal and Child Health Programs/National Academy for State Health Policy).

Joni Hollis, RN, MSN, CNL, CCM has been with CMS since 2002 and is the Bureau Chief, Director of Clinical Operations, for the Office of Children's Medical Services Managed Care Plan and Specialty Programs. She supports Dr. Brosco in his role as the Title V Children with Special Health Care Needs Director.

Robert W. Brooks, PhD, has been an epidemiologist within the Division of Children's Medical Services since 2017. He serves as the Project Director of the State Systems Development Initiative (SSDI) grant, which funds supplemental data support to Florida's Title V CYSHCN program.

III.C.2.b.iii. Title V Program Partnerships, Collaboration, and Coordination

The Department continues to cultivate several collaborative partnerships aimed at furthering its MCH goals and objectives, several of which are discussed below.

Since 1993, the Department has been awarded the SSDI grant, which serves as a complement to the Title V MCHBG Program. The primary goal of the SSDI grant is to promote the use of data and analytical work to support evidence-based MCH decision-making.

The Division of Public Health Statistics and Performance Management has the primary responsibility for facilitating the collection, analysis, and dissemination of health statistical data; the implementation of the local health department clinic management system; and coordination of community health assessment and health improvement planning processes. The MCH Section works closely with this division in several areas including: review of requests for MCH data; review of research proposals; and performing analyses and evaluations of MCH initiatives and programs.

The Department receives funding each year from the Administration for Children and Families to administer the Title V State Sexual Risk Avoidance Education Program. The goal of the program is to reduce the incidence of teen births and sexually transmitted infections through education on building healthy relationships and avoiding risky behaviors.

The Department receives funding each year from the federal Office of Population Affairs for the Title X Family Planning Grant. The Department's Family Planning Program provides services using minimum guidelines for routine contraceptive management. Services include: education and counseling; history and physical assessment; provision of contraceptives; and treatment of related problems such as anemia and sexually transmitted infections. Florida has a robust statewide program with 67 local health departments and 143 clinic sites throughout the state. All women and men of childbearing age can receive services. Priority is given to teens and women ages 20-44 that are at or below 150 percent of the federal poverty level.

There are two federally recognized tribes in Florida - the Miccosukee Tribe of Indians of Florida and the Seminole Tribe of Florida. While these are the two main tribes whose governmental headquarters are in Florida, there are people of American Indian descent from more than 150 different tribes, each with their own distinct set of cultural beliefs. In total, the federally-recognized tribes comprise less than an estimated 5 percent of the American Indian population in the state.

The Office of Minority Health and Health Equity supports and provides resources to a volunteer committee called the American Indian Health Advisory Council (AIHAC). The AIHAC was formed initially in the HIV/AIDS Program Prevention Section. Since its inception, the AIHAC has grown to serve as a resource for agencies and officials such as the Florida

Department of Health and its various programs, Florida American Indian governments, American Indian non-governmental organizations, and other organizations that serve American Indian persons, households and/or descendants in Florida. The AIHAC serves by providing a forum for discussion of the health, health care needs, and concerns of American Indian persons.

The Department partners with Florida State University (FSU) to encourage nursing students to intern with the Department. The Department also has a partnership with Florida Agricultural and Mechanical University (FAMU) to encourage students working towards their Masters of Public Health degree to participate in a summer rotation between their first and second years.

The Department participates in and contracts with the Florida Perinatal Quality Collaborative (FPQC), which is located at the University of South Florida, Lawton and Rhea Chiles Center for Healthy Mothers and Babies. The FPQC seeks to create an all-inclusive culture of cooperation and transparency across the specialties of obstetrics, neonatology, pediatrics and all fields engaged in maternal and infant health care by bringing together the specific expertise of physicians, nurses, nurse-midwives and all specialists involved with perinatal-related health care. Over recent years, the Department has partnered with the FPQC on the following initiatives, Access LARC, Mother's Own Milk, Obstetric Hemorrhage, and Hypertension in Pregnancy.

CMS contracts with the University of South Florida (USF) for the Florida Health and Transition Services (FloridaHATS) Program to collaborate with communities to develop local/regional health care transition coalition sites in Pensacola, Jacksonville, and Tampa.

CMS area offices may choose to employ a Family Support Worker who has personal experience raising a child with special needs. Additionally, each Early Steps program has a Family Resource Specialist.

The Family Network on Disabilities is Florida's Family to Family Health Information Center. CMS works with this organization and the Family Café to promote family involvement in health care decision-making.

The Department's Public Health Dental Program, in partnership with the Florida Dental Hygiene Association and Head Start, conducted the two Head Start Oral Health Surveillance Projects in 2014-2015 and 2017-2018 to provide oral health screenings in more than 47 Head Start centers across 29 counties for each project. Screening teams consisting of a dental hygienist and a recorder reached over 2,000 Head Start children during both projects and provided screenings, oral health education and referrals for follow-up care through providers in local health departments, Federally Qualified Health Centers, and private dentists registered as Medicaid providers.

The PHDP promotes prevention and emphasizes the importance of public health measures such as dental sealants and community water fluoridation through collaborative activities implemented by dental partner organizations.

III.C.2.c. Identifying Priority Needs and Linking to Performance Measures

Linkage of State Selected Priorities with National Performance and Outcome Measures

- NPM 1 - Percent of women, ages 18 through 44, with a past year preventive medical visit.
- NPM 3 – Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU).
- NPM 4 - A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months.
- NPM 5 - Percent of infants placed to sleep on their backs.
- NPM 8 - A) Percent of children ages 6 through 11 and B) adolescents 12 through 17 who are physically active at least 60 minutes per day.
- NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others.
- NPM 11 - Percent of children with and without special health care needs having a medical home.
- NPM 14 - A) Percent of women who smoke during pregnancy and B) Percent of children who live in households

where someone smokes.

Priority needs identified by the state's needs assessment process helped the Department select the eight national performance measures chosen for programmatic focus by the Title V program. Following is a discussion of the measures, why they were selected, and their linkage to the selected state priorities.

NPM 1: Percent of women with a past year preventive medical visit

This measure was chosen because of the link to the state's priority to improve access to health care for women, to improve preconception health. The Title V program focuses on both preconception and interconception health, fully recognizing the importance of improving the health of all reproductive age women to ensure better birth outcomes and healthier babies. Women's health at all ages of the lifespan is important and contributes to the well-being of Florida families as too often women are the primary caregiver for families.

NPM 3: Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

This measure was chosen because of the link to the state's priority to promote the health and well-being of pregnant women and the most fragile newborns to reduce maternal and fetal/infant mortality as well as reduce the risk of developmental disabilities in infants. CMS contracts with 11 Regional Perinatal Intensive Care Centers (RPICCs) and two obstetrical satellite clinics across the state to deliver optimal medical care to high-risk pregnant women and sick or low birth weight infants. With Title V funding support from the Department, participation of RPICCs in the Florida Perinatal Quality Collaborative (FPQC) has grown.

NPM 4: A) Percent of infants who are ever breastfed, and B) Percent of infants breastfed exclusively through 6 months

This measure was chosen because of the link to the state's priority to promote breastfeeding to ensure better health and reduce low food security for infants and children. Promoting breastfeeding is an important focus of the Title V program. It has also been recognized as a major health benefit to both infant and mother, as well as an enhancement of maternal/child bonding. The Department provides breastfeeding promotion and support activities through many programs, including WIC, the Child Care Food Program, Healthy Start, and the Bureau of Chronic Disease Prevention (BCDP). The BCDP utilizes funding from the Preventive Health and Health Services Block Grant to support hospitals in counties that have prioritized breastfeeding in their Community Health Improvement Plan and support women living in counties with low breastfeeding initiation rates. The Title V program also has a long history of coordinating with the Department's WIC program on many of their breastfeeding initiatives, such as breastfeeding peer counseling and establishing local health department policies to protect, promote, and support breastfeeding as the preferred, normal method of infant feeding. The Florida SSDI project has published and presented data on the benefits of breastfeeding practices.

NPM 5: Percent of infants placed to sleep on their backs

This measure was chosen because of the link to the state's priority to promote safe and healthy infant sleep behaviors and environments, including improving support systems and the daily living conditions that make safe sleep practices challenging. The Department formed a Statewide SUID Workgroup that provides input on the state work plan to reduce sleep-related infant deaths, and created a logic model for conducting training efforts on safe sleep practices for health care providers, the Florida Hospital Association and other birthing centers, parents, caretakers, and the public. These activities, along with data showing that safe sleep initiatives have a significant impact on reducing infant mortality, made the selection of this measure a valid choice for the Title V program.

NPM 8: Percent of children ages 6-11 and adolescents ages 12-17 who are physically active at least 60 minutes per day

This measure was chosen because of the link to the state's priority to promote activities to improve the health of children and adolescents and promote participation in extracurricular and/or out-of-school activities in a safe and healthy

environment. Studies have shown that for many children, a decline in physical activity begins in middle school, and those children who continue to be physically active through middle school and high school have a much better chance of being physically active adults. Focusing on children and adolescents to increase physical activity can have a tremendous impact on improving health throughout the life span, by reducing obesity and the risk of many chronic diseases.

NPM 9: Percent of adolescents, ages 12-17, who are bullied or who bully others

Bullying is a priority for the Title V program. This focus can have an impact on improving health throughout the life span, by looking at adverse childhood experiences and the long-term impact and risk factors associated with many chronic diseases. Bullying is defined as: attack or intimidation with the intention to cause fear, distress, or harm that is either physical (hitting, punching), verbal (name calling, teasing), or psychological/relational (rumors, social exclusion); a real or perceived imbalance of power between the bully and the victim; and repeated attacks or intimidation between the same children over time. Bullying is a serious detriment to a child's health, sense of wellbeing, safety, education, and emotional development, and greatly increases the risk of self-injury and suicide.

NPM 11: Percent of children with and without special health care needs having a medical home

This measure was chosen because of the link to the state's priority to increase access to medical homes and primary care for children with special health care needs. A patient-centered medical home (PCMH) provides accessible, continuous, comprehensive, family-centered, coordinated, compassionate, culturally effective medical care. All children should have a PCMH, but the PCMH is especially advantageous for children with special health care needs as they typically require coordination of care between primary care providers and specialists.

NPM 12: Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

This measure was chosen because of the link to the state's priority to improve health care transition for adolescents and young adults with special health care needs to all aspects of adult life. Transition from pediatric to adult health care has become a priority nationwide and effective health care transition is especially important for children with special health care needs as they are less likely to finish school, go to college, or secure employment. When transition is successful, it can maximize lifelong functioning and well-being.

NPM 14: A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes

This measure was chosen because of the link to the state's priority to promote tobacco cessation to reduce adverse birth outcomes and secondhand smoke exposure to children. Smoking during pregnancy increases the risk of miscarriage and certain birth defects such as cleft lip or cleft palate. It can cause premature birth and low birth weight. Smoking during pregnancy is a risk factor for SIDS, and secondhand smoke doubles an infant's risk of SIDS. Exposure to SHS increases a child's risk of respiratory infections and common ear infections. Children with asthma who are exposed to secondhand smoke are likely to experience more frequent and more severe attacks, which can put their lives in danger.

Linkage of State Selected Priorities with State Performance and Outcome Measures

Based on the findings from assessing the needs and examining strengths/capacity phases, a scoring tool worksheet was developed. The tool entailed scores for issue brief packets (completed topic briefs, SOARs, capacity needs scoring sheets), and a section for public health impact based on the recommendation of an advisory workgroup member. To remain objective, a three-member Needs Assessment Scoring Team (CMS staff, including one with lived-experience as a CYSHCN caregiver) were asked to review the materials and use the tool to submit anonymous and individual scores, to rank the eleven priorities. To ensure inter-rater reliability, project managers of the needs assessment process individually computed the averages from the scorers. After, a one-page ranking document, containing the average scores for each scoring tool section and total score for all potential priority areas, was created and presented to leadership. After a debriefing,

leadership selected Patient Centered Medical Home (PCMH) and Mental/Behavioral Health (MH) as the 2020 Title V Needs Assessment priorities.

Adequate insurance, transition, access to care, and workforce development were the additional top-scoring priorities. Adequate insurance was not selected as a final priority for CYSHCN because Medicaid and KidCare have specific roles in insurance coverage for the State of Florida. Likewise, there is also the Florida Covering Kids & Families at the University of South Florida's Chiles Center that focuses on insurance coverage; CMS does participate on their hard-to-reach subcommittee and will continue to partner and collaborate with statewide stakeholders pertaining to adequate insurance for children and youth with special health care needs. Although not identified as final priorities, transition, early screening, family partnership, access to care, and workforce development, are enveloped as tenets under the umbrella of the PCMH concept, along with family partnership, and early screening.

Sustainment of MH and PCMH as state priorities from the previous five-year reporting cycle is backed by a review of literature, findings from stakeholder input, ongoing regional needs assessment efforts, and the successful initiation and planning of interventions that will be evaluated for effectiveness.

Over the past several years, CMS has transitioned towards making a greater impact on population health by focusing efforts on the infrastructure-building level of the MCH Health Services Pyramid. Hence the focus on National Outcome Measure 17.2 Systems of Care as the foundation for this most recent needs assessment process; PCMH is associated with NOM 17.2, linked to NOM 19 (health status) and NOM 25 (able to obtain care) a component of the National Standards for Systems of Care, and overtly derives from national performance measure (NPM) 11, with the aim of increasing access to medical homes and primary care. PCMH will drive improvement by: 1) Providing Education and/or technical assistance; 2) Increase the number of caregivers that feel like partners in their child's care; 3) Increase number of designated PCMHs in underserved areas; and 4) Increase the number of adult care providers that will accept CYSHCN.

Mental/Behavioral Health is a state performance measure (SPM) that is directly derived from NOM 18, concerned with increasing access to behavioral health services. The focus of this priority will be education and/or technical assistance, behavioral health integration, and prevention of these conditions. The needs assessment findings coupled with prior investments and fruitful collaborative efforts, upholds continuing Patient-Centered Medical Home and Mental/Behavioral Health as priority needs for Children and Youth with Special Health Care Needs.

- SPM 1 - The percentage of children with a behavioral health condition who receive treatment consistent with their diagnosis.
- SPM 2 - The percentage of low-income children under age 21 who access dental care.
- SPM 3 - The percentage of parents who read to their young child age 0-5 years

SPM 1: Percent of children with a behavioral health condition who receive treatment consistent with their diagnosis

This measure was chosen because of the link to the state's priority to improve access to appropriate mental health services to all children. Increasing the number of children who are referred to timely and appropriate treatment will improve health outcomes and the child's ability to function optimally at home, at school, and in society.

SPM 2: The percentage of low-income children under age 21 who access dental care

This measure was chosen because of the link to the state's priority to improve dental care access for children and pregnant women. Oral health is vitally important to overall health and well-being. Research has shown a link to diabetes, heart and lung disease, stroke, respiratory illnesses, and other conditions for pregnant women, including the delivery of preterm and low birth weight infants.

SPM 3: Increase the percentage of parents who read to their young children

This measure was chosen because of the link to the state's priority to address social determinants of health that influence

the relationship between health status and biology, individual behavior, health services, social factors, and policies. Encouraging parents to read to their children has a positive impact, including improvement in the parent-child bond, improved language development in children, and increased positive parenting.

III.D. Financial Narrative

	2018		2019	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$19,243,069	$19,478,535	$20,922,688	$19,444,613
State Funds	$155,212,322	$155,212,322	$155,212,322	$155,212,322
Local Funds	$0	$0	$0	$0
Other Funds	$0	$0	$0	$0
Program Funds	$0	$0	$0	$0
SubTotal	$174,455,391	$174,690,857	$176,135,010	$174,656,935
Other Federal Funds	$28,194,845	$27,465,676	$16,568,999	$16,085,512
Total	$202,650,236	$202,156,533	$192,704,009	$190,742,447

	2020		2021	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$20,940,088	$19,837,392	$20,703,392	
State Funds	$155,212,322	$15,527,544	$15,527,544	
Local Funds	$0	$0	$0	
Other Funds	$0	$106,092,392	$0	
Program Funds	$0	$33,592,386	$139,684,778	
SubTotal	$176,152,410	$175,049,714	$175,915,714	
Other Federal Funds	$29,375,939	$25,338,492	$29,183,143	
Total	$205,528,349	$200,388,206	$205,098,857	

	2022	
	Budgeted	Expended
Federal Allocation	$20,767,711	
State Funds	$15,575,783	
Local Funds	$0	
Other Funds	$106,055,754	
Program Funds	$33,580,785	
SubTotal	$175,980,033	
Other Federal Funds	$29,786,523	
Total	$205,766,556	

III.D.1. Expenditures

The FDOH has an ongoing commitment to provide maternal and child health (MCH) services to women and children in Florida. This commitment includes continued support to local health departments, local programs, and other providers for MCH services.

The expenditures for FY2020 are presented in Forms 2, 3a, and 3b of the Title V Block Grant application. The Department received $20,703,392 in Title V funds in FY 2020 (October 1, 2020- September 30, 2021), and plans to expend the full amount by the end of the grant period (September 30, 2021). As in prior years, the FDOH will meet the Title V requirement as specified in Section 501(a)(1)(D): a 30/30/10 split, as shown on Form 2.

CMS previously reported in its FY2020 application to be budgeted for $9,423,040. However, alignment of funding categories for the MCH Healthy Babies program resulted in a reduction for a revised and actual expenditure budget of $7,593,549 for CYSCHN from the MCH Block Grant. For FY2020 Florida continued with the significant public health emergency impact of COVID-19. CMS utilized $610,000 of its funding to support the state's public health services and system needs, including public health campaigns.

Children's Medical Services (CMS) has various other federal funding sources. CMS receives $1,517,738,215 for Title XIX, $184,425,179 for XXI CHIP funding which supports the operations of the CMS Health Plan and the services provided to its approximate 88,000 members. For Medicaid and the Children's Health Insurance Program (CHIP) related activities, CMS draws down the allowable federal match. CMS also receives $10,076,399 in general revenue for additional programs and activities separate from the CMS Plan.

For CYSHCN that are uninsured or underinsured CMS received $451,150 of nonfederal funding that is used to provide direct specialty health care services, as part of its Safety Net program in FY20/21. While statutorily CMS Title V funds are expected to be used as part of this program, its allocation is used for operational support of the program.

CMS's general revenue dollars are also used to provide support for the systems of care that serve CYSCHN through various legislative supported member projects and historical specialty contracts with various tertiary care systems condition specific programs, with Title V CYSHCN funding used to help supplement. This state-federal partnership helps ensure a cadre of condition specific specialists across the state to help support access and quality services for CYSHCN. Specific to CMS's existing tertiary care system partners, Title V CYSHCN funding supported a quality improvement learning collaborative, in partnership with the National Institute for Child Health Quality (NICHQ). The secondary gain of this framework of peer to peer learning, is the formation of a statewide network of existing partners.

Title V CYSHCN funding is allocated to address the priority need for access to Patient Centered Medical Homes, in partnership with the University of Central Florida (USF) HealthARCH program for practice transformation technical assistance. CMS provides funding to Florida Health and Transition Services (FloridaHATS) Program at the University of South Florida for transition related activities including website hosting; consultation; resource identification; and education for youth, families, and providers.

In support of the priority need and SPM to increasing access for children's mental/behavioral health treatment, Title V CYSHCN funding is provided in partnership to 5 regional academic hubs, that come together to help support a statewide network, for its Behavioral Health Integration model. This model includes provision of telepsychiatry, skill building training for primary care providers, family community resource identification and linkage through care coordination services. Funding also supports a third-party evaluation component to systematically evaluate and analyze the standardized outcomes from the 5 academic universities and the State's current statewide pediatric psychiatry hotline, which includes the addition of care coordination services.

Electronic documentation and robust data reporting are essential infrastructure elements for monitoring and tracking outcomes in the CYSHCN population. The migration of the CMS Health plan to a contracted vendor, created the need for the development of an in-house custom build application to meet the needs of programs serving vulnerable populations, such as medical foster care, under the CMS's Title V CYSHCN purview. This also includes referrals and management for CYSHCN clinical eligibility determination, safety net and children's multidisciplinary assessment team.

Title V CYSHCN funding was also used to support:

- JaxHATs program, a clinic-based youth transition to adulthood program
- Promotion of community system of care collaboration, including two pilot models for regional networks for access

and quality.

- Statewide and regional family leaders
- Florida Family Leader Network focused on professional development for family leaders statewide

Title V funds also support outreach and education activities for the Information Clearinghouse on Developmental Disabilities Advisory Council. This advisory council, mandated by section 383.141, Florida Statutes, was created to advise the Department in establishing and maintaining a clearinghouse of information related to developmental disabilities on its website, Bright Expectations.com. The clearinghouse provides resources and information on developmental disabilities for pregnant women, health care providers, parents, and families. The council is comprised of health care providers and caregivers who provide health care services for persons who have developmental disabilities. The council consists of nine members, serving four year terms, as follows:

- Three members appointed by the Governor
- Three members appointed by the Senate President
- Three members appointed by the Speaker of the House of Representatives

Title V funds were expended to enhance the MCH system of care and ensure more infants have the best possible start in life.

The Department continues to partner with the Florida Perinatal Quality Collaborative (FPQC) housed at the University of South Florida. The collaborative works on several projects: First is the Maternal Opioid Recovery Effort (MORE). This project's purpose is to work with providers, hospitals and other stakeholders to improve identification, clinical care and coordinated treatment/support to pregnant women with opioid use disorder and their infants. The project focuses on OUD screening, prevention, treatment and comprehensive discharge planning. The second initiative is to reduce the state's caesarian section rate. Lastly, the FPQC has started an initiative this year on Family Centered Care to increase awareness of the importance of skin to skin contact for newborns in the neo-natal intensive care until.

As a component of Florida's Healthy Babies Initiative, the Department allocated $1,200,000 in Title V funding divided among all 67 county health departments to implement evidence-based community projects aimed at addressing social determinants of health and lowering disparities in infant mortality.

To increase the percentage of parents who read to their young children, the Department provided Title V funding to county health departments through Schedule C and a statement of work that included an option to create a reading rich environment in waiting room areas equipped with children's reading tables, chairs, bookshelves, children's books, etc. Funds were also available to establish a Reach Out and Read (ROR) program.

In the following additional examples, Title V funds were used to:

- Promote school-based sealant programs to children and increase positive consent rates from parents by producing and disseminating a postcard that explains dental sealants and their effectiveness in preventing tooth decay.
- Promote awareness of the Adolescent Health program housed at FDOH.
- Partner with Division of Disease Control and Health Protection/ Sexually Transmitted Disease program to bring awareness to congenital syphilis
- Promote awareness of suicide prevention.
- Partner with Count the Kicks to implement a statewide stillbirth prevention campaign
- Develop a focused maternal mortality campaign
- Partner with CMS and Violence and Injury Prevention on Safe Sleep
- Partner with CMS and Violence and Injury Prevention on drowning prevention
- Hire a contract staff to work on the FDOH's opioid use initiatives

III.D.2. Budget

Florida's FY 2021 maternal and child health (MCH) program budget totals $ $20,767,711. This is $64,319 more than the FY2 020 amount. States must match every four dollars of federal Title V funding they receive by at least three dollars of state and/or local funding. The required state general fund match for Florida for FY 2021 is $15,575,783. This match is met with the general revenue appropriation that the FDOH receives for Healthy Start.

Florida's Title V program complies with allocating and spending at least 30 percent of the federal allotment for preventive and primary services for children and at least 30 percent for services for children with special health care needs. A total of $6,268,063 is budgeted toward preventive and primary care services for children, which is 30.1 percent of the FY 21/22 estimated allotment. A total of $4,189,484 is budgeted for Pregnant Women and all others which is 20.17 percent of the total block grant funds. A total of $8,991,764 is budgeted for children with special health care needs.

For FY 21/22, the estimated administrative cost is $1,318,400 or 6.35 percent of the federal allotment, which is below the 10 percent threshold for administrative spending. The budgeted administrative costs in this application represent the grant funds used to administer the Title V program for MCH and include, but are not limited to, contract management, budgeting, policy development, personnel, and clerical support for these functions. Florida will continue to provide the maintenance of effort amount of $155,212,322 as required.

For FY 2022, the FDOH has budgeted a total of $29,786,523 in other federal funds under the control of the Title V MCH Director. This includes $3,988,211 for the Sexual Risk Avoidance Education Grant, $1,872,466 for the Rape Prevention and Education Program, $11,200,000 for Title X Family Planning, $650,000 for the Perinatal Mental Health Grant, $450,000 for the Preventing Maternal Deaths Grant and $11,625,846 for the School Health Program.

For the coming year, Title V children and youth with special health care needs (CYSHCN) funds have been budgeted towards the following activities and initiatives to address the identified priority needs and enhance the system of care for the CYSHCN population:

- Addressing the priority need for access to Patient Centered Medical Home (PCMH) contract continuation with University of Central Florida's HealthARCH for practice transformation technical assistance working towards a population health model and the addition of a behavioral health (BH) designation for those already PCMH accredited.
- Addressing the priority need for access for mental health treatment:
    - Continued contracts with the five university academic centers operating as regional Pediatric Behavioral Health Hubs (BHH)
    - Contract for external evaluation of program and outcomes measures collected by the BHH's
    - Statewide pediatric psychiatric consultation line with care coordination
    - System Mapping
    - Media Campaigns
- Transition related initiatives including updating transition education modules, new transition website and continued support of JaxHATS, a clinic based direct service transition program.
- Professional networking and development for family leaders throughout the State, as part of the Florida Family Leader network.
- Support of one statewide and five regional family leaders.
- Statewide network for access and quality continuing quality improvement learning collaboration, in partnership with the National Institute for Children's Health Quality, for tertiary care systems condition specific programs serving CYSHCN under contract or agreement with the FDOH.
- Support of the FDOH's contracts with tertiary care system condition specific programs such as HIV and Hematology/Oncology.
- Community collaboration, including continued support for two pilot regional networks for access and quality models.
- Direct services for uninsured or underinsured as statutorily required as part of the FDOH's Safety Net Program.

Title V funding will continue to be provided through Schedule C and a Statement of Work to all 67 county health departments. Depending on their local needs, county health departments are able to provide well-woman preventative health visits; prenatal care; education for chronic disease management and prevention for pregnant women; preconception health counseling; reproductive health services; dental care services for pregnant women and children; and activities that promote access to care, health literacy, community engagement and/or establishment of policies that positively influence social and economic conditions to address the social determinants of health.

The FDOH will continue to use Title V funding for four regional part-time nurse abstractors, an epidemiology staff for data

analysis, and additional staff as needed to support the statewide, voluntary Maternal Mortality Review Committee.

For the coming year, Title V funds have been budgeted towards the following activities and initiatives to enhance service delivery and positive health outcomes for the MCH population:

- The FDOH will continue to use Title V funding to provide interconception care (ICC), which is not reimbursable by Medicaid, through the Healthy Start program.
- Contracts with 11 Fetal Infant Mortality Review (FIMR) projects through the Healthy Start program to provide for the implementation of FIMR services to address the behavioral, environmental, and structural processes that may impact fetal and infant deaths, to learn more about why infants die, and to propose recommendations for change.
- Contract with the Florida Perinatal Quality Collaborative to engage perinatal stakeholders to improve maternal and infant health outcomes through design, implementation, and evaluation of processes, and to enhance quality improvement efforts.
- Contract with the Ounce of Prevention Fund of Florida to identify, fund, and evaluate innovative prevention programs for at-risk children and families using general revenue funding. One specific project under this contract is to provide culturally linguistic and age appropriate books to Reach Out and Read sites throughout Florida to support one of the MCH priorities and performance measures. Additionally, funds support public education on critical prevention issues facing Florida's at-risk children and families.
- Continuing to establish new school-based dental sealant programs in Florida.
- Continue Title V funding for county health departments to create a reading rich environment in waiting room areas equipped with children's reading tables, chairs, bookshelves, and children's books. Funds may also be used to establish a Reach Out and Read (ROR) program
- Title V funding will be available to county health departments to establish a Fresh Access Bucks (FAB) Initiative. Fresh Access Bucks encourages healthy behaviors by making fresh, local produce more affordable and accessible to SNAP recipients while supporting Florida farmers and enhancing local economies. FAB increases the purchasing power of SNAP participants by providing a one-to-one match for Florida grown fruits and vegetables. A SNAP cardholder who spends $10 of their benefits receives an additional $10 to purchase more fresh, local produce. The goals of FAB are to increase access to and affordability of fruits and vegetables in underserved communities and increase awareness of the importance of eating fresh fruits and vegetables. This program strategically targets farmer's markets in and around food deserts, low-income communities, and along transportation routes.
- Title V funding will be available to county health departments to implement the Protocol for Assessing Community Excellence in Environmental Health (PACE EH) in high-need communities, to assess neighborhood and community identified social determinants of health needs and provide action plans to address the top issues as defined by the communities.
- Title V funding will be available to county health departments to facilitate partnerships with local birthing hospitals to obtain Cribs for Kids Safe Sleep Hospital Certification.
- Title V funding will be used to work in partnership with the Division of Disease Control and Health Protection/Sexually Transmitted Disease program to bring awareness to congenital syphilis.
- Title V funding will be used to partner with the Count the Kicks to continue a statewide education campaign.
- Title V funding will be used to implement a focused maternal mortality campaign.
- Title V funding will be used to partner with CMS and Violence and Injury Prevention on Safe Sleep.
- Title V funding will be used to partner with CMS and Violence and Injury Prevention on drowning prevention.

III.E. Five-Year State Action Plan

III.E.1. Five-Year State Action Plan Table

State: Florida

Please click the links below to download a PDF of the Entry View or Legal Size Paper View of the State Action Plan Table.

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

III.E.2. State Action Plan Narrative Overview

III.E.2.a. State Title V Program Purpose and Design

MCH and CMS partnerships that are critical to accomplishing the goals and mission of the MCH Block Grant include, but are not limited to, interagency, cross agency, community, state, and national relationships. Cross agency partnerships include the Agency for Health Care Administration (Florida's Medicaid Agency) and the Department of Children and Families (DCF).

For MCH, community, state, and national relationships include the FDOH's county health departments, the Florida Perinatal Quality Collaborative, the March of Dimes, Florida State University College of Medicine, Florida Hospital Association, Florida Healthy Start Coalitions, numerous state agencies, and CityMatCH. CMS relationships include family organization partnerships with Family Network Disabilities and their Family STAR program, Florida's MCHB training program the University of Florida (UF) Pediatric Pulmonary Program for Florida's Family Leader Network, Family Café, and the National Association on Mental Illness. Both MCH and CMS partner with the Association of Maternal & Child Health Programs (AMCHP) and the National Maternal Child Health Workforce Development Center.

Established leadership roles and relationships in regional communities provide a local voice to drive needs and state action planning. CMS has partnerships with Florida's university systems to facilitate the achievement of its Title V priorities. This includes the University of Central Florida's HealthARCH program for patient-centered medical home (PCMH) transformation. In addition, for CMS's priority need for access to mental health treatment partners include Florida State University, University of Florida, University of South Florida, Florida International University and University of Miami. MCH partners with the USF Florida Perinatal Quality Collaborative and the USF Lawton and Rhea Chiles Center for Healthy Mothers and Babies on numerous issues and initiatives. MCH partnered with Northwestern University; Florida's Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program; and the Florida Association of Healthy Start Coalitions to implement the Mothers and Babies curriculum as a component of Florida's Healthy Start and MIECHV programs.

Through Healthy Start, the MCH Section assists pregnant and interconception women, infants, and children up to age three in obtaining the health care, education, and social support needed to ensure an optimal chance at better health across the lifespan. The MCH Section is responsible for the oversight of the MCH Block Grant and program direction for public health activities as they relate to advancing the health of the maternal and child population. The goals of the program are to promote positive maternal, infant and child health outcomes and early childhood development. To provide program direction, MCH epidemiologists examine life course indicators that are related to infant mortality and data on health outcomes that are related to infant mortality and maternal mortality.

CMS continues to focus on population health approaches to help strengthening the system of care that serves CYSHCN. This includes a regional needs assessment process to drive action planning at the community level with an emphasis on whole-community systems approaches with the prioritization given to the linkage or integration of multisector services systems to maximize protective factors and minimize risks for CYSHCN. CMS utilized the *Standards for Systems of Care for Children and Youth with Special Health Care Needs 2.0* and identified priority needs as foundational elements in contractual language and tasks in its programming. This includes CMS's community based systems of care pilot project known as Regional Networks for Access and Quality (RNAQ) and it's State Networks for Access and Quality (SNAQs) initiative which includes 32 university or tertiary care programs across the state, focused on seven specific condition or disease states (e.g. HIV, Diabetes).

HRSA awarded funds to the FDOH for its project, *The Development of a Sustainable Screening and Treatment Model to Improve Maternal Mental Health Outcomes in Florida*, which will increase the capacity of health care providers to deliver evidence-based screening, treatment, and referral for perinatal mental health services in three targeted regions. To increase routine screening and referral by prenatal care providers, the project team has developed and implemented a perinatal screening and treatment model to directly train health care providers in prenatal health care practices and birthing hospitals. The project team also trains community mental health providers in evidence-based management of perinatal mental health disorders and provide access to a professional perinatal psychiatrist consultation to increase the use of evidence-based therapeutic interventions for perinatal depression. To increase access to services, the project team has expanded mental health and substance use referral networks through provider outreach, developed community resource guides, and expanded the Moving Beyond Depression and Mothers & Babies programs in statewide home visiting programs.

Addressing the unmet need for pediatric behavioral health treatment, while building on existing community and state resources, CMS contracted with five academic universities across the state to implement evidence-based behavioral

health integration models. The universities, known as behavioral health hubs (BHH), then partner with pediatric primary care providers and mental health systems of care in their community or region. This model includes a needs assessment, skill-building training and technical assistance to build capacity of primary care providers to be able to identify and treat common pediatric mental health conditions while increasing access through telehealth consultation services. The regional network partnerships then come together to form a statewide network, the Florida Pediatric Mental Health Collaborative (FPMHC) which includes state agency representation such as Florida's Department of Children and Families (DCF) Substance and Abuse Mental Health (SAMH) program, the Agency for Health Care Administration (AHCA); and state organizations such as Florida's CHIP program Florida Kid Care and family representation through the National Alliance for Mental Illness. The goal of the FPMHC is to share resources, needs, best practices, ensure quality improvement and address sustainability. An external evaluator is used to analyze data within and across BHH and includes the measurement of collaboration with the FPMHC.

Community and state-level planning for CMS and MCH will focus on ensuring the availability of services and supports during critical or sensitive periods, looking at both the service systems and community-based initiatives, to address services, facilitation of access, and additional supports and resources as needed. Authentic family engagement, and intentional application of health equity in continually assessing the possibility for disparity in the incorporation of population and community-based strategies, will help address social determinants of health, changing environments, and other root causes of poor health outcomes.

III.E.2.b. State MCH Capacity to Advance Effective Public Health Systems

III.E.2.b.i. MCH Workforce Development

Title V plays an important role in allowing the FDOH to maintain capacity within the Title V workforce. Title V funding helps ensure the FDOH can maintain an adequate workforce in the State Office to preserve, enhance, and expand services for the Title V population.

The FDOH encourages MCH program staff to complete the AMCHP MCH Leadership Competencies module. Participants in the training learn how to identify core MCH leadership competencies, outline the knowledge and skill areas required of MCH leaders, provide a conceptual framework for the development of an MCH leader, and describe how MCH leadership competencies might be used by a variety of audiences.

The State of Florida Library provides state employees with a library account. Through this service, MCH staff can access hundreds of databases and can request journal articles and other materials, most at no charge.

The FDOH's Public Health Research Section offers the Research Excellence Initiative, a year-long educational program that provides structured education and mentoring to FDOH professionals interested in conducting research, epidemiology, and program evaluation. The program was developed to promote high quality, innovative research and develop experienced researchers who can promote excellence by serving as role models and mentors, foster collaborations, and promote research on FDOH priorities.

Additionally, the FDOH partners with the University of South Florida (USF), College of Public Health to engage potential and current early-to-mid-career supervisors and managers who demonstrate leadership potential for USF"s Public Health Executive Leadership Program. This program is a leadership development initiative intended to equip future leaders in the FDOH with knowledge and skills necessary to lead in today's challenging health care and public health environment. The program is comprised of:

- A seven-month program in Public Health Executive Leadership for 20 CHD staff and 10 State Health office staff.
- Tailored leadership workshops (face-to-face) and other activities/assignments to meet the needs of the FDOH.

CMS is enhancing workforce training and growth to staff statewide by sponsoring evidence-based training that focuses on core competencies and industry standards for public health workers. The training ensures staff, who are experts in their specific disciplines, have the proper education, skills, and experience needed to deliver appropriate services in the achievement of desirable outcomes for population health.

CMS furthered collaboration with the UF's Pediatric Pulmonary Center and their family leader to provide statewide training to support and increase the skills of family leaders across organizations. The 2020 FFLN Annual Summit included skill building topics on resonate leadership, advancing equity and cultural humility in working with families experiencing medical complex issues, and future directions on family and youth engagement. Due to Covid-19, this summit had to be held virtually, which allowed the opportunity to expand and welcome attendees from across the country and U,S. territories. The fourth annual summit in September 2021 will also be a virtual setting, with intent on increasing both our state and national reach. In 2020 and early 2021, the FFLN director, Title V CYSHCN administrator and statewide family leader presented at six national conferences and two state conference about this collaborative partnership. Per the annual survey feedback after each yearly summit, the FFLN has received high rates of positive impact regarding personal growth of its members.

It should be noted that in the event of an emergency, unless granted a temporary exemption from emergency duty, all FDOH employees may be required to work before, during and/or beyond their normal hours or days in a special needs shelter, Red Cross shelter, Emergency Operations Command Center; or perform other emergency duties, including but not limited to response to or threats involving any disaster or threat of disaster, man-made or natural.

III.E.2.b.ii. Family Partnership

Family engagement and voice is an essential element for CYSHCN and the Maternal and Child Health programs in the FDOH. CMS has six paid family leader positions dedicated to Title V activities. This includes a state level position that works on: needs assessments, program development, evaluation, quality improvement, performance management, advisory committees, presentations, etc. This position is essential in collaborating with various state and national stakeholder groups, serving in an advisory capacity, allowing for an exchange of resources and opportunities. The statewide family leader serves as the Florida Family Delegate to the Association for Maternal & Child Health Programs (AMCHP), was selected for the 2020-21 cohort of AMCHP's Leadership Lab, the 2020-21 MCHB-funded National Care Coordination Academy, the AMCHP workgroup on Public Health Emergency Preparedness, and the Expecting Health/NCC Family Center's National Workgroup on Diversity, Equity, and Inclusion. In addition, five regional family leaders, with lived experience representing the family voice for CYSHCN, provide community health outreach, education, technical assistance and resource linkage. This community family perspective helps continually inform needs assessment planning at both the local and state levels.

CMS values its long-term partnership with the Family Network on Disabilities (FND), which serves as both the Family-to-Family Health Information Center and the Family Voices state affiliates. FND is instrumental in helping CMS gather youth and family feedback including dissemination of satisfaction surveys through their broad-reaching social media platforms. This year this included a 2020 Covid-19 family survey, and a resulting "Return to School Decision Tool" that was developed for both families and providers.

Florida continues to collaborate with the University of Florida's Pediatric Pulmonary Center, one of our state MCHB partners, for training activities that serve to strengthen and advance CYSHCN family leaders across all related organizations, agencies, and community stakeholder groups. This includes an annual professional development summit and quarterly educational activities specific for family leaders, their champions and emerging public health professionals. This partnership has evolved into the Florida Family Leader Network (FFLN) -- which has grown to 247 members, in three-and-a-half years. In the summer of 2020, the FFLN launched their public-facing website (floridaleaders.org) which has seen steady usage growth of 1,723 visits during the first six months. The 2020 FFLN Annual Summit included skill building topics on resonate leadership, advancing equity and cultural humility in working with families experiencing medical complex issues, and future directions on family and youth engagement. Due to Covid-19, this summit had to be held virtually, which allowed the opportunity to expand and welcome attendees from across the country and U.S. territories. The fourth annual summit in September 2021 will also be a virtual setting, with intent on increasing both our state and national reach. In 2020 and early 2021, the FFLN director, Title V CYSHCN administrator and statewide family leader presented at six national conferences and two state conference about this collaborative partnership. Per the annual survey feedback after each yearly summit, the FFLN has received high rates of positive impact regarding personal growth of its members. Family/Professional partnership is also being promoted through a CMS statewide quality improvement initiative with multiple specialty contract sites. From 2019 through present, 29 local medical specialty teams covering populations based on seven specific medical conditions* work together to implement quality improvement projects. Each local team has received education and supporting technical assistance specific to including a patient/family partner in the co-design and development of their respective QI projects.

To model and advance the value of family/professional partnerships, CMS staff-wide performance management teams are now forming for a new multi-year workforce development process. Each team is expected to include a family partner to provide lived experience perspectives in the ongoing staff development and performance initiative. Future plans for CMS include development of further specific training and tips sheets related to family/youth engagement, partnership and leadership at the individual, organizational and systems levels for both families and providers, as well as staff and contractors, to include impact measurement. As well, there is intent to deepen current collaborations with stakeholders, and broaden new engagement with family-run and community-based organizations with respect to increasing youth and family engagement.

Maternal and Child Health programs in the FDOH promotes family engagement in the development, review, and improvement of policies, procedures, and practices affecting services families receive. Further, the MCH programs recognize social determinants of health to understand the conditions in which people live, learn, work, and play is critical to MCH services.

Families are involved at all levels of the Healthy Start and MCH Healthy Babies programs. Services are provided based on the needs, desires, and choices of families. Healthy Start programs convene teams that conduct a needs assessment and service delivery plan to address gaps and barriers to services for pregnant women and young children in their community. Many teams include pregnant women and families to ensure the family voice is a driving factor of priorities and resources. Additionally, a recipient of home education services works as the Program Administrator for the Healthy Start program at the state level.

The FDOH MCH programs are enhancing its family engagement strategies using the framework embedded in the policy statement: *Family Engagement from the Early Years to the Grades* developed by the U.S. Department of Health and

Human Services and the U.S. Department of Education. This framework will increase the programs' capacity to support families as essential partners in service provision that promotes children's learning and development, nurture positive relationships between families and staff, and support families at all levels of the system.

III.E.2.b.iii. MCH Data Capacity

III.E.2.b.iii.a. MCH Epidemiology Workforce

The FDOH encourages MCH epidemiology staff to complete the Training Course in MCH Epidemiology offered by The Health Resources and Services Administration, Centers for Disease Control and Prevention, and CityMatCH as part of their ongoing effort to enhance the analytic capacity of state and local health agencies. The training course is an intensive program, combining lectures, discussion, hands-on exercises, and opportunities for individualized technical assistance. Additionally, FDOH requires MCH epidemiology staff to complete six to ten hours of epidemiology related classes for ongoing professional development.

Florida relies on a well-trained workforce of epidemiologists. There are three full time employees (FTEs) who focus on MCH epidemiology along with one CDC assignee.

MCH Epidemiology Workforce	
Title	**Credentials**
Budget, Procurement, Grants, and Data Analysis Program Administrator	MPH, RHIA
MCH Epidemiologist	PhD, MS
MCH Epidemiologist	PhD
Senior Epidemiologist, CDC Assignee	ScD, MS

Roles/Responsibilities

- To assist in the review and analysis of data for MCH, reproductive health, school health, oral health, adolescent health, sexual violence prevention, and the Florida Pregnancy Risk Assessment Monitoring System (PRAMS), in addition to other health related data and information that impact policy and program development, including the compilation of related data-based and informed reports, fact sheets, white papers and other products in a timely and accurate manner for distribution to internal and external customers, as needed and/or requested.
- To perform research, data analysis, and evaluation using various statistical and data managing software packages, such as SPSS, SAS, Stata, R, SQL, and MS Access to collect and analyze data pertaining to maternal and child health and various the other Bureau of Family Health Services programs and projects identified above, as well as other health related issues. This includes maintaining knowledge of relevant data sets and availability, data tools/software and trends.
- To initiate and carry out statistical analysis, including formative and summative evaluations of maternal and child health and various other programs and activities within the Bureau of Family Health Services, along with other health related data and activities, in addition to providing an ongoing assessment of data capacity and quality related to linkages, access and use of key and relevant data sets.
- To provide research and statistical analysis support, training, and technical assistance to programs within the Bureau of Family Health Services, including interpreting data and communicating same to Bureau and Division of Community Health Promotion staff, local Departments of Health, and external partners.
- To conduct epidemiologic research to identify determinants and risk factors for maternal and child health and other health related outcomes in Florida.

III.E.2.b.iii.b. State Systems Development Initiative (SSDI)

The Florida State Systems Development Initiative (SSDI) program, which resides in the Division of Children's Medical Services (CMS), submitted a successful, non-competitive application for the 2017-2022 project period. Title V Block Grantresources allocated for Florida's SSDI program have been instrumental in the ongoing effort to track and expand electronic access to key Maternal and Child Health (MCH) indicators. These efforts are accentuated by supplemental activities focused on data initiatives that serve Children and Youth with Special Healthcare Needs (CYSHCN), abused and neglected children, and strengthening Title V programs that serve these populations.

FLHealthCHARTS, a community health assessment resource toolset, continues to act as the principal stage in which national and state performance measures are updated and displayed in real-time. In addition to the required indicators, theSSDI team generates supplemental variables which include new profiles and keyword searches designed to capture data relevant to Title V performance measures. These efforts have provided new MCH related variables within FLHealthCHARTS that encompass data points related to newborn screenings, Child Abuse/Neglect and CYSHCN. The funding received through the SSDI grant represented the primary funding source necessary to program the information into the public forum. The dynamic capacity of FLHealthCHARTS continues to drive innovative data-infrastructure changes to SSDI dissemination protocols.

Amplifying our Business Intelligence (BI) utilization continues to revolutionize how data is collected, analyzed, visualized and applied to support data-driven decision making throughout CMS programs. Dynamic mapping technologies bolster Title V initiatives and have been instrumental in disseminating complex information in a visual realm, establishing an engaging atmosphere for stakeholder meetings. These initiatives extend beyond the federal and state levels, providing dynamic data support to local stakeholders where real-time access to information can provide the necessary resources to drive significant improvement in Florida's at-risk MCH populations.

Linkages between MCH relevant databases remain a key objective, particularly within Title V programs that serve the same or similar populations. Presently, the SSDI team has begun merging databases within CMS to track vulnerable populations of children through each stage of development, beginning with newborn screening and culminating in the Early Steps and Child Protection Team programs. Collaborative efforts to expand these initiatives beyond the Florida Department of Health are currently being executed with the Departments of Education and Office of Early Learning. These linkages are providing invaluable insight into the efficiency and reliability of programs that serve MCH populations and will be a fundamental resource regarding future data-driven decisions required for timely collection and reporting of MCH-related materials.

Research to evaluate emerging issues that impact MCH populations served by Title V programs is ongoing. These include utilizing state-level population data (ex: Behavioral Risk Factor Surveillance System, Child Abuse Death Review, National Survey of Children's Health, vital statistics, etc.), workgroups and other supplemental enterprises to advance Title V program evaluation. These initiatives also improve interagency communication which has translated into improved data systems while simultaneously decreasing duplication of efforts. To note, SSDI staff have assisted with several data-driven initiatives designed to improve the health and well-being of Florida's MCH population:

- In 2020, SSDI staff continued to provide data support to an ongoing and expanding project initiated by the state Child Abuse Death Review (CADR) team. Analyzing data between 2014-2020, the Child Abuse Death Review Team, along with Florida's vital statistics and the National Center for Disease Control, have consistently identified sleep-related death as the number one cause of preventable child death in Florida. In 2019 the Sleep Baby Safely program, a campaign aimed at reducing incidents of sleep-related child death in Florida's communities through educating new parents on safe sleep practices, was implemented through Title V grant funding made available by CMS, allowed the Child Abuse Death Review Unit to provide the selected local CADR Committees with items imprinted with safe sleep messaging to create Welcome-Baby bags for each new parent for 10-12 months. Committee members are partnering with local birthing hospitals, neo-natal hospital staff, pediatrician offices, first responders, and others in the community who have contact with parents of newborns. The campaign utilizes a universal safe sleep message and provides valuable items to help strengthen the new parent's engagement in ensuring that their baby sleeps safely "every night and every nap." The campaign has seen promising results in counties where previously implemented and the initiative has sparked optimism that Florida can strategically reduce sleep-related deaths.
- Mapping and itemizing MCH relevant databases maintained by CMS has been instrumental in collaborative efforts requiring the merge of multiple sets of data. These efforts are illustrated by the substantial work done over the past year regarding new born screening hearing (NBS/H), where merges between the NBS/H and databases such as Vital Statistics and hospitalization records have illuminated potential late onset hearing loss cases developed or diagnosed

after predetermined screening dates. These findings will be vital in reexamining screening intervals for hearing and the potential for expansion of these dates, perhaps aligning with other pediatric health checkups into early childhood. Early detection afforded through timely screenings are imperative to families who will need information and resources regarding their child's disability and development.

- Bolstering MCH stakeholders with extensive peer reviewed research remains a primary focus of Florida's SSDI unit. These studies provide the necessary information to inform data-driven policy design and implementation. Florida's SSDI team has continued to focus on child welfare issues, as the team is strategically located within the Bureau of Child Protection and Special Technologies. These efforts are illustrated in extensive work done with the CADR team and stakeholders with initiatives in safe-sleep practices, drowning and suicide prevention. Currently, submission of a risk factor publication regarding sleep practices is ongoing. Furthermore, we have expanded these enterprises to other MCH emerging issues, including but not limited to, Newborn hearing screening, the impacts of COVID-19 on vulnerable MCH populations and violence prevention.

III.E.2.b.iii.c. Other MCH Data Capacity Efforts

The FDOH's Maternal and Child Health (MCH) section currently has four epidemiologists on staff dedicated to collecting and reporting timely MCH data requests. They have access to numerous data files, including but not limited to: vital records, screening, Florida Community Health Assessment Resource Tool Set (CHARTS), Medicaid data, Florida Maternal Mortality Review Committee (FLMMRC) data, fetal and infant mortality review data (FIMR), and data across numerous FDOH programs.

The MCH Section and Agency for Health Care Administration's (AHCA) Division of Medicaid participated in a national learning collaborative facilitated by the Association of Maternal and Child Health Programs (AMCHP). The goal of the project was to establish a long-term data sharing partnership to increase the ability of staff to access and analyze data that informs policy, programs, and practice, to improve the health of Florida's MCH and Medicaid populations. The proposed projects of mutual interest to the FDOH and AHCA were to conduct an evaluation to assess maternal and infant health outcomes in the Medicaid population who do and do not receive Florida's Healthy Start Program services, and to examine postpartum contraceptive use among women on Medicaid. These analyses are underway.

As a result of the learning collaborative, in May 2017, MCH Epidemiology staff successfully established the formal data sharing agreement with AHCA. AHCA provides Medicaid claims, encounters, and eligibility data to the FDOH, and in turn, the FDOH provides AHCA with copies of any evaluation and analytic reports resulting from analysis of AHCA data prior to public release.

The MCH Section is often tasked with responding to requests from FDOH leadership and state legislators for the most up-to-date quarterly data on fetal and infant mortality, birth rate, C-sections, and preterm births. A dashboard for each of these indicators will be updated monthly and quarterly and presented in tables containing results of statistical significance tests and data by county and state total. Aggregate data will be displayed in tables and graphs. Having an automated process for these inquiries would improve program efficiency. Because of time-related challenges due to competing priorities and limited staff, the MCH Section worked with a resident physician, who has exceptional statistical programming skills, from Nova Southeastern University College of Osteopathic Medicine and led the effort of building this dashboard with FDOH guidance.

III.E.2.b.iv. MCH Emergency Planning and Preparedness

The National Oceanic and Atmospheric Administration (NOAA) predicts how active a hurricane season will be. In 2018 Hurricane Michael made landfall as an unprecedented Category 5 Hurricane in the Florida Panhandle region with maximum sustained wind speeds of 140 knots (161 mph) and a minimum pressure 919 mb. The storm caused catastrophic damage from wind and storm surge, particularly in the Panama City Beach to Mexico Beach to Cape San Blas areas. The widespread damage spread well inland as Hurricane Michael remained at hurricane strength into southwest Georgia and the effects can still be seen and felt today.

Fortunately, emergency and disaster preparedness are not new concepts in Florida. In fact, the FDOH has an entire division dedicated to emergency preparedness and community support. Through this division, the FDOH shares recommendations for individual, community, environmental, and health care systems preparedness. This includes information on current hazards, how to make a plan for you and your family, children's disaster preparedness, behavioral health, special needs sheltering, and how to "stop the bleed." These tools are designed to help individuals and their families prepare for any disaster. Listed below is more information about different preparedness teams that that the MCH Section often consults with in preparation for and response to emergencies:

- Individual preparedness includes tools and resources to help an individual and their family prepare for any disaster. This includes information about current hazards and important information on what to do before, during, and after public health emergencies.

- Community preparedness relies on the ability to develop informed, empowered, and resilient health care systems and residents. With adequate information, resources, and tools, communities are better prepared to prevent, protect against, mitigate, respond, rebound, recover, and adapt to threats and all-hazards.

- Health care system preparedness ensures that there is capacity and capability for provision of critical public health and medical services in order to reduce the potential for adverse health outcomes during any event.

- The training and exercise staff are a team of professionals with a wide range of knowledge and expertise, dedicated to providing a streamlined process to accomplish an organization's educational, training and exercise goals.

- During emergencies, the Environmental Health preparedness team can provide guidance to both Incident Command and county health departments regarding possible human health risks from environmental components. They can also provide information to be used by the county health departments during responses that involve accidental spills, waste disposal, and water contamination. To maximize success, trainings and exercises are conducted with partners throughout the state.

One of the greatest challenges faced by the state health office and county health departments during disasters is balancing emergency responsibility with continuing routine delivery of public health services for Florida citizens. This has been challenging during the COVID-19 pandemic response.

One strategy the FDOH has implemented to mitigate this is the FDOH has engaged in Project Public Health Ready (PPHR). PPHR is a criteria-based training and recognition program that assesses local health department capacity and capability to plan for, respond to, and recover from public health emergencies. PPHR aims to protect the public's health and strengthen the public health infrastructure by equipping local health departments with sustainable tools to plan, train, and exercise using a continuous quality improvement model. PPHR is a partnership program comprised of the Florida Department of Health, the National Association of County and City Health Officials (NACCHO), and the Centers for Disease Control and Prevention (CDC) that recognizes effective county health department preparedness programs.

The PPHR criteria are nationally-recognized standards for local public health preparedness. NACCHO regularly updates the criteria to align with recent federal initiatives, including the Centers for Disease Control and Prevention Public Health Emergency Preparedness (CDC PHEP) capabilities and Public Health Accreditation Board's (PHAB) Standards and Measures.

PPHR criteria are comprised of three goals:

- Goal 1: All-hazards Preparedness Planning

- Goal II: Workforce Capacity Development
- Goal III: Demonstration of Readiness through Exercise or Real Event

The MCH Section and the Division of Emergency Preparedness and Community Support work together to ensure that the MCH population is considered when developing strategies to mitigate impacts on different populations. Consideration is made for our providers who provide direct services to the maternal and child health population. One example of this partnership was at the beginning of the COVID-19 pandemic Florida's Healthy Start Coalitions were hearing that clients were not able to obtain diapers and wipes. This information was shared with emergency response teams and missions were completed to get these supplies to families. This not only included connecting community partners who had reserve supplies, but also communication with private entities (I.e. Wal-Mart, Publix, etc.) to know when items were restocked.

Additionally, during severe weather or a hurricane, a Special Needs Shelter (SpNS) may be activated. A SpNS is for "someone who during periods of evacuation or emergency, requires sheltering assistance, due to physical impairment, mental impairment, cognitive impairment or sensory disabilities." Chapter 64-3, Florida Administrative Code The Florida Department of Health, Bureau of Preparedness and Response administers a statewide Special Needs Shelter Program to assist County Health Departments in addressing the special medical needs of people in their community.

SpNS are designed to meet the needs of people who require assistance that exceeds services provided at a general population shelter. A SpNS is a place to go when there is no other sheltering option. Shelters may be activated during an emergency event to provide mass care for people who cannot safely remain in their home. Often stSpNS are intended to provide, to the extent possible under emergency conditions, an environment that can sustain an individual's level of health. SpNS are often setup in public facilities and have food and water available. Shelter staff offer basic medical assistance and monitoring. Clients and their caregivers will have a small sleeping area and they maintain back-up electricity for light and essential medical equipment.

III.E.2.b.v. Health Care Delivery System

III.E.2.b.v.a. Public and Private Partnerships

The Maternal and Child Health Section achieves success through collaboration with our many partners. The MCH Section works very closely with many University and State partners including, Florida State University, the University of South Florida, the University of Florida, the Agency for Health care Administration (AHCA), the Department of Children and Families, and the Department of Education.

Additionally, we work closely with the Florida Association of Healthy Start Coalitions (FAHSC). Florida's Healthy Start Program is a free home visiting program available in all 67 counties. Their services include providing education and care coordination to pregnant women and families of children under the age of three. The goal of the program is to lower risk factors associated with preterm birth, low birth weight, infant mortality, and poor developmental outcomes.

The University of South Florida houses the Florida Perinatal Quality Collaborative (FPQC). The FPQC a consortium of professionals dedicated to the advancement of perinatal health care. The FDOH partners with the FPQC to implement quality improvement initiatives to improve the perinatal health of mothers. Often these initiatives are based on the findings of the Florida Maternal Mortality Review Committee (FLMMRC). The FLMMRC is made up of physicians, nurses, and other professionals from around the state who review pregnancy associated deaths to determine if they were pregnancy related.

We partner with the AHCA on multiple initiatives as well, including recognizing hospitals that achieve the Healthy People 2030 goal of reducing cesarean births among low-risk women with no prior births to 23.6 percent. The State Surgeon General and the Secretary of AHCA both recognize the hospitals with certificates and awards. An award ceremony in 2021 is currently being planned.

The AHCA also hosts birth outcome workgroups that the FDOH participates in. These workgroup meetings are excellent opportunities that pull together providers, managed care plans, community partners, and hospitals systems. These meetings have allowed partners to come together and discuss successes and challenges and develop ways to further initiatives that are working and find solutions to address barriers.

The Office of Children's Medical Services and the AHCA work closely to ensure CYSHCN are provided quality healthcare and related services through the Managed Care Plan Bureau and Specialty Programs Bureau. The CMS Plan, operated by a contracted vendor, is a Medical Managed Assistance (MMA) plan specifically designed to serve eligible Title XIX and Title XXI CYSHCN with serious and chronic special health care needs. The CMS Plan is in its' third year of implementation of its new model, Florida's Title V CYSHCN priorities and programming, and feedback from families and communities. Through this new model, the CMS Plan works with providers on value-based care and other innovative and effective payment models. The CMS Plan continues to keep care coordination as a cornerstone of the program. Every child is assigned to a care coordinator and interaction frequencies are based on a tiered system. The CMS Plan offers expanded benefits and programs, designed to support the child and family. Dental services for CMS Plan Medicaid enrollees, are covered under a separate Medicaid dental plan.

Outreach for determination of eligibility for the CMS Plan occurs through both state program and community efforts. During the Title XIX (Medicaid), Title XXI (Florida KidCare) or Division of Disability Determination (SSI) eligibility process, if there is indication of having a special healthcare need an electronic referral is sent to the CMS Clinical Eligibility Unit (CEU). Manual referrals can be generated by families, providers or community stakeholders. Upon referral the CEU conducts a family-based clinical screening to determine clinical eligibility, with daily response files sent electronically back to the referring entities. If their child is eligible, families may choose to enroll them in the CMS Plan or if they desire, opt out. A clinical eligibility re-screening process occurs every three years.

Through the joint interagency agreement between FDOH and AHCA, CMS's Specialty Programs Bureau operates the Children's Multidisciplinary Assessment Teams (CMAT) and Medical Foster Care (MFC) programs. The CMAT provides eligibility determination for the long services of medical foster care, skilled nursing facility, or model waiver. CMS's CMAT staff includes a pediatric medical director, nurse and social worker who provide a comprehensive assessment and facilitate the multidisciplinary staffing for determination of service eligibility. CMAT team members include a representative from AHCA's Medicaid Program or their MMA Plan, a representative from the Agency for Persons with Disabilities, and if under the age of three, a representative from Early Steps. The CMAT staffing process includes a review of completed medical, activities of daily living, and psychosocial assessment with all staffing participants. This provides the opportunity for participants to clarify information, obtain updates, and discuss any challenges, while also providing a venue for clinical education and recommendations from experts representing the child's system of care. Through a team consensus building process, eligibility is determined and the recommended level of care, which authorizes the level that MFC parent can bill the MMA plan for their MFC service provision.

Florida's MFC program is a collaborative partnership between CMS, AHCA's Medicaid Program and the DCF's Child Welfare Program. The CMS MFC program provides specialized training and support for foster parents to become Medical Foster Care parent providers through Medicaid. MFC parent providers are then credentialed by MMA Plans to be reimbursed for their daily MFC service provision to eligible children admitted into their home. The CMS MFC team, provides ongoing monitoring, child-specific trainings, and technical assistance to the MFC parent and child. Medicaid's MMA Plan is responsible for coordinating direct health service provision for their enrolled member who is also admitted into the MFC program, this includes responsibility of the MFC Plan of Care which operates as the prescription of the services the MFC parent must provide in the home. The MFC program includes multiple stakeholders including biological and pre-adoptive parents, and relative caregivers. Other partners include the MMA plans, the child welfare agency, the guardian ad-litem program, community providers and specialists, etc.

Together for Kids Program is Florida's Program for All-Inclusive Care for Children and an example of a state waiver that was created in partnership with AHCA to meet the complex needs of CYSHCN. This program is administered by CMS and AHCA and serves children enrolled in the CMS Plan with life threatening and life limiting illnesses. Together for Kids Program Providers are hospices who deliver pain and symptom management services, including nursing and social services supports, activity therapies, and respite care.

The Behavioral Health Network (BNet) was created pursuant to Florida Statute requiring FDOH to contract with DCF to provide behavioral health services to Title XXI eligible CYSHCN. BNet is a statewide network of behavioral health service providers who serve non-Medicaid eligible children ages 5 to 19 years with mental health or substance use disorders. BNet treats the entire spectrum of behavioral health disorders and provides both children and parents with behavioral health planning and treatment services for the duration of the child's enrollment. CMS Title V, CMS Health Plan, and DCF collaborated on quality improvement activities to increase the number of referrals and enrollments to the BNET program, which had been decreasing over time, for increased access to this outpatient BH treatment program.

In support of the Florida's priority need to increase access to pediatric mental health treatment, CMS Title V facilitates the Florida Pediatric Mental Health Collaborative. The FPMHC shares relevant information, including best practices, resources, needs and challenges for solution focused problem solving as part QI. Stakeholders include state agency partners such as DCF's Substance Abuse and Mental Health program, AHCA and key state organizations including Florida Kid Care and family representatives from the Florida Chapter of the National Alliance on Mental Illness, as well as a variety of pediatric, mental health, and psychiatric clinical champions from five academic university partners, operating as pediatric mental health access teams. Additional stakeholders include the Florida Chapter of the American Academy of Pediatrics, the Florida Academy of Family Physicians, the American Association of Child and Adolescent Psychiatry, Department of Education, and Department of Juvenile Justice.

III.E.2.b.v.b. Title V MCH – Title XIX Medicaid Inter-Agency Agreement (IAA)

The FDOH and the Agency for Health Care Administration (AHCA) renew their interagency agreement every three years and are currently in the process of renewing this agreement. The purpose of this agreement is to ensure an understanding between the AHCA and FDOH and delineate areas of responsibility regarding the operation and administration of the programs or services such as the Certified Nurse Assistant Registry; Children's Multidisciplinary Assessment Team; Family Planning Waiver; Healthy Start, Medical Foster Care, and Preadmission Screening and Resident Review. The AHCA may delegate certain programmatic or operational functions related to the administration of the Florida Medicaid program, as directed in Florida law. The AHCA and FDOH are cooperative partners in overseeing certain functions related to programs and services for Medicaid recipients.

The AHCA is the single state agency responsible for the administration of the Florida Medicaid program, authorized under Title XIX of the Social Security Act (the Act). In accordance with Title 42 Code of Federal Regulations (CFR), Section 431.10, the AHCA may not delegate and must retain ultimate responsibility and authority to supervise the Florida Medicaid State Plan and waivers and to develop policies, rules, and regulations related to the Florida Medicaid program.

For this agreement, AHCA's responsibilities include, but are not limited to:

- Coordinate with FDOH on the submission of Medicaid state plan amendments or waiver amendments related to the programs.
- Provide FDOH with an opportunity to review any proposed Medicaid state plan amendments or waiver amendments related to the programs described in this agreement prior to submission to the CMS.
- Enroll and register Florida Medicaid providers.
- Respond to inquiries from FDOH requesting technical assistance or policy clarifications from AHCA related to duties and responsibilities specified in the interagency agreement.
- Monitor compliance with all aspects of this Agreement.

FDOH is responsible for Florida's public health system designed to promote, protect, and improve the health of all people in the state. The FDOH is also responsible for oversight and implementation of several federal state-funded programs and services, including:
Coordinate with AHCA on Medicaid state plan amendments, legislative budget requests, administrative rules, and contracts related to the programs described in the agreement.
Participate in stakeholder meetings that are relevant to the programs described in this agreement.

- Provide AHCA with programmatic information, upon request, for delegated activities specified in the agreement to address federal reporting requirements or to be responsive to state and/or federal audit requests or findings.
- Administration of maternal, infant, and child health programs.
- Administration of the Children's Medical Services program to provide services for children with or at risk of having health care needs.
- Regulation of nursing professionals, including certified nursing assistant.
- Providing the following County Health Department services:
    - Basic family healthcare,
    - Infectious disease control; and
    - Environmental health services.
- Determining medical eligibility and/or the level of Medicaid reimbursement through the Children's Multidisciplinary Assessment Team (CMAT) for:
    - The Model Waiver,
    - Nursing facility services for individuals under the age of 21 years; and
    - Medical foster care (MFC) services.
- Operation and programmatic management of the Family Planning (FP) Waiver

In order for Medicaid administrative expenditures to be claimed for federal matching funds, the following requirements must be met:

- Costs must be “proper and efficient” for the state’s administration of its Medicaid state plan (Section 1903(a) of the Act).
- Costs related to multiple programs must be allocated in accordance with the benefits received by each participating program (OMB Circular A-87, as revised and now located at 2 CFR 200). This is accomplished by developing a method to assign costs based on the relative benefit to the Medicaid program and the other government or non-government programs.
- Costs must be supported by an allocation methodology that appears in the state’s approved Public Assistance Cost Allocation Plan (42 CFR 433.34).
- Costs must not include funding for a portion of general public health initiatives that are made available to all persons, such as public health education campaigns.
- Costs must not include the overhead costs of operating a provider facility.
- Costs must not duplicate payment for activities that are already being offered or should be provided by other entities or paid through other programs.
- Costs may not supplant funding obligations from other federal sources.
- Costs must be supported by adequate source documentation.

The AHCA and the FDOH have implemented the Family Planning Medicaid Waiver Program, also known as "Family Planning Medicaid for Today's Woman." A woman may qualify for this program if she:

- Is between the ages of 14 and 55
- Has lost full Medicaid services for any reason in the past 24 months
- Wants to have family planning services
- Is not pregnant
- Has not had a hysterectomy or sterilization
- Has a household income less than or equal to 185% of the current federal poverty level
- Services include under the Family Planning Medicaid Waiver Program include:
- Physical exams which may include a pap smear, breast exam, and sexually transmitted disease testing
- Family planning counseling and pregnancy test
- Birth control supplies including condoms
- Colposcopies and treatment for STDs which are limited to a six-week period after a family planning exam, counseling visit, or supply visit
- Related pharmaceuticals (medicines and antibiotics) and laboratory test

As a result of the implementation of the Federal Omnibus Budget Reconciliation Act of 1989, Florida Medicaid expanded reimbursement for medically necessary services to children with complex medical needs. The CMAT within the FDOH, is an interagency coordination effort of AHCA, DCF, and the Agency for Persons with Disabilities, and ensures individuals under 21 years of age with complex medical needs, are assessed and staffed to determine the medical eligibility level of care most appropriate for nursing facility or Model Waiver services.

The CMAT in combination with parents or legal representatives and identified community-based resources, shall:

- Assist the child’s family or legal representative in acquiring the knowledge, skills, supports, and services needed to meet medical, developmental, educational, and emotional needs.
- Provide information on alternative settings for long-term care services when services in the biological home are not possible.
- Prevent or reduce prolonged stays in hospitals upon identification of a child in need of long-term care services.
- Schedule and invite all applicable agencies, entities, and participants for the level of care determination staffing when nursing facility or Model Waiver services are requested, or when seeking continuation.

- Provide referrals to caregivers for technical assistance and guidance.
- Educate parent(s), and legal representatives, as applicable, on the requirements for program and service eligibility.
- Provide a person-centered care and service plan for the child receiving Model Waiver services.

The Medical Foster Care (MFC) Program is a coordinated effort between the Florida Medicaid Program within AHCA, DOH Children's Medical Services, and the DCF's Community Based Care Program to provide family-based care for medically complex children under the age of 21 in foster or shelter care status who cannot safely receive care in their own homes. The MFC Program establishes and trains foster parents to provide MFC services for children that are assigned to the provider's care by identifying and approving through the CMAT process.

CMS provides the assessment and staffing services for CMAT and provides medical consulting, nursing and social work care coordination, and administration of the MFC program. The objectives of MFC are to:

- Reduce the high cost of medical treatment associated with medically complex and fragile children by eliminating the need for long-term institutional care.
- Enhance the quality of life and allow medically complex and fragile foster children to receive home-based services specific to their medical needs that will enable children to develop to their fullest potential.
- Return children to a safe home with birth parents or relatives as soon as possible.
- Facilitate the provision of a timely alternative permanent placement for children who cannot be returned to their families of origin.
- Reduce the risk of medical neglect or abuse for children once they are returned to their own homes.
- Ensure that families who are reunited with children who have continuing medical problems will receive medical training in the care of their child prior to his or her return.

III.E.2.c State Action Plan Narrative by Domain

State Action Plan Introduction

The mission of the Florida Department of Health is to protect, promote, and improve the health of all people in Florida through integrated state, county, and community efforts. The Title V MCH Block grant enhances the state's ability to promote prevention, capacity and systems building, public information and education, family-centered systems of care, outreach and program linkage, technical assistance to communities, and other core public health functions.

A comprehensive Needs Assessment was completed in 2020 that determined Florida's priorities, targeted funds to address priorities, and the methods and measures to address the priorities to meet the state's needs. The Needs Assessment informed the development of the State Action Plan with the intent of supporting and promoting the development and coordination of systems of care for women of childbearing age, infants, and children, including children with special health care needs (CSHCN).

The priorities, strategies, and objectives set forth in the State Action Plan address national and state performance measures that align with the goals of the Title V MCH Block grant. The State Action plan emphasizes collaborative efforts with state partners, families, Institutes of Higher Education, and additional stakeholders to strengthen the health, safety, and well-being of mothers and children in Florida. The evidence-based strategies have been developed with the goal of eliminating health disparities, improving birth outcomes, and advancing the health status of women, infants, children, youth, and families.

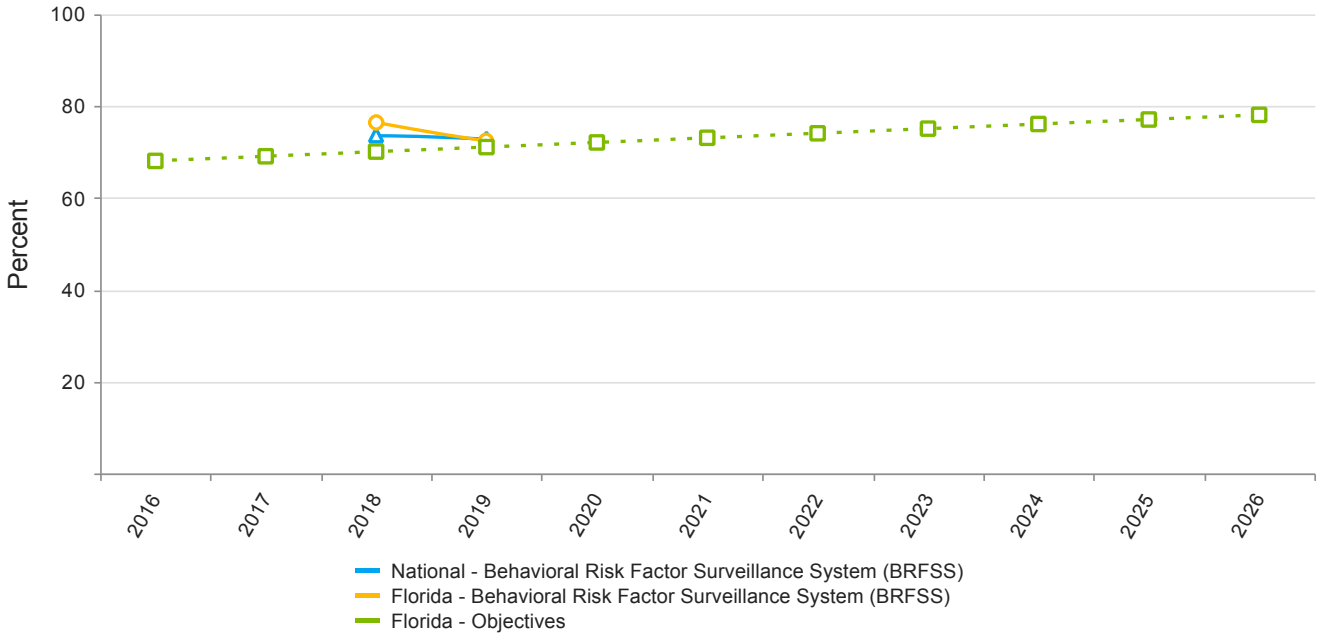
Women/Maternal Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2018	73.4	NPM 1 NPM 14.1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2015_2019	18.1	NPM 1 NPM 14.1
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2019	8.7 %	NPM 1 NPM 14.1
NOM 5 - Percent of preterm births (<37 weeks)	NVSS-2019	10.6 %	NPM 1 NPM 14.1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2019	28.0 %	NPM 1 NPM 14.1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2018	6.1	NPM 1 NPM 14.1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2018	6.0	NPM 1 NPM 14.1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2018	4.1	NPM 1 NPM 14.1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2018	2.0	NPM 1 NPM 14.1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2018	218.9	NPM 1 NPM 14.1
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2018	87.6	NPM 14.1
NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy	PRAMS	Data Not Available or Not Reportable	NPM 1
NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations	SID-2018	6.9	NPM 1
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	91.3 %	NPM 14.1
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2019	16.2	NPM 1
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth	PRAMS-2019	13.0 %	NPM 1

National Performance Measures

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year
Indicators and Annual Objectives



Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective					72
Annual Indicator				76.4	72.2
Numerator				2,630,508	2,531,649
Denominator				3,443,178	3,508,023
Data Source				BRFSS	BRFSS
Data Source Year				2018	2019

Previous NPM-1 BRFSS data for survey years 2015, 2016 and 2017 that was pre-populated under the 2016, 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable with 2018 survey data.

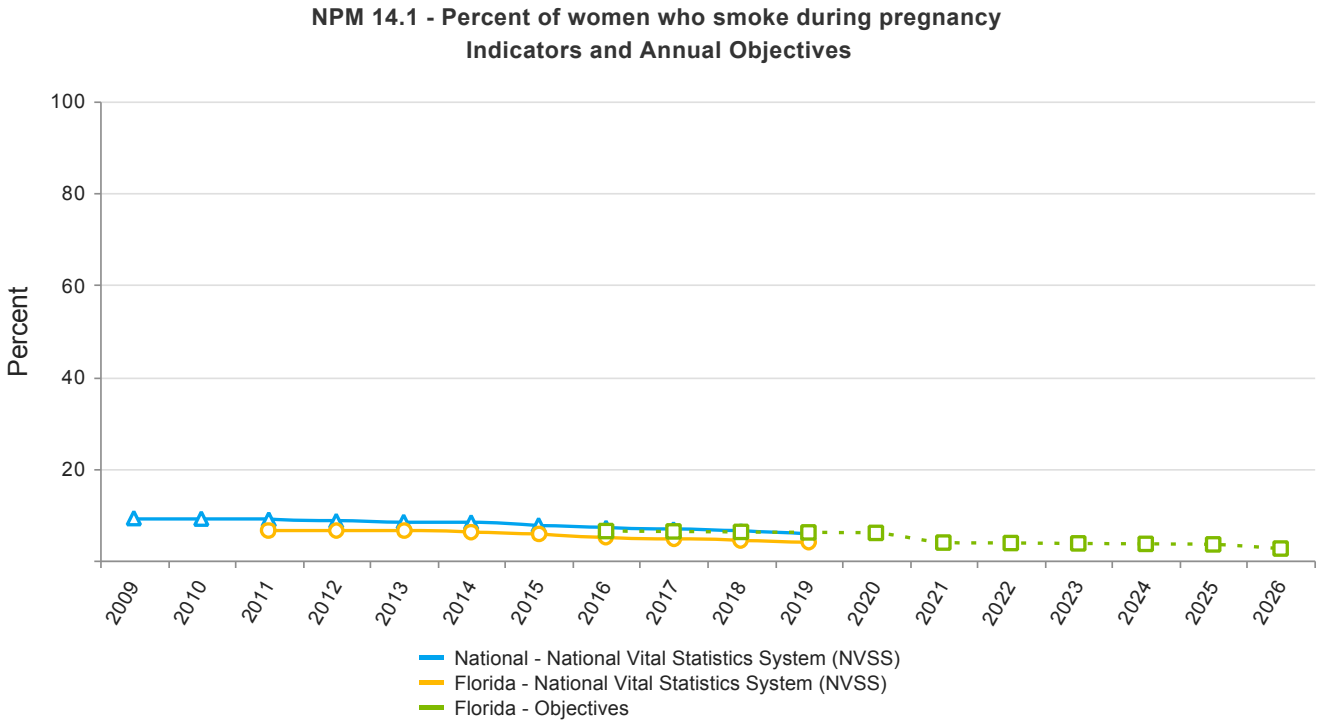
Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	73.0	74.0	75.0	76.0	77.0	78.0

Evidence-Based or –Informed Strategy Measures

ESM 1.1 - The number of interconception services provided to Healthy Start clients

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		27,000	44,000	44,500	45,000
Annual Indicator	25,558	43,507	26,508	54,553	62,509
Numerator					
Denominator					
Data Source	Well Family System	Well Family System	Well Family System	Well Family System	Well Family System
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	63,009.0	63,509.0	64,009.0	64,509.0	65,009.0	75,984.0



Federally Available Data					
Data Source: National Vital Statistics System (NVSS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	6.5	6.4	6.3	6.2	6.1
Annual Indicator	5.8	5.1	4.8	4.5	4.1
Numerator	12,970	11,454	10,639	9,836	9,011
Denominator	223,231	224,109	221,925	220,538	219,141
Data Source	NVSS	NVSS	NVSS	NVSS	NVSS
Data Source Year	2015	2016	2017	2018	2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	4.0	3.9	3.8	3.7	3.6	2.7

Evidence-Based or –Informed Strategy Measures

ESM 14.1.1 - The number of Smoking Cessation Reduction in Pregnancy Treatment (SCRIPT) services provided to Healthy Start clients

Measure Status:	Active

State Provided Data				
	2017	2018	2019	2020
Annual Objective			7,000	7,250
Annual Indicator			9,736	8,020
Numerator				
Denominator				
Data Source			Well Family System	Well Family System
Data Source Year			2019	2020
Provisional or Final ?			Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	8,270.0	8,520.0	8,770.0	9,020.0	9,270.0	9,850.0

State Action Plan Table

State Action Plan Table (Florida) - Women/Maternal Health - Entry 1

Priority Need

Improve access to health care for women, specifically women who face significant barriers to better health, to improve preconception health.

NPM

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Objectives

1. By 2026, decrease the number of syphilis cases among women ages 15-44 years from 1,792 (2019: FLCHARTS) to 1,493.

2. By 2026, decease the percentage of women age 18-44 in Florida who did not have a routine checkup from 27.7 percent to 20.7 percent.

3. By 2026, increase the number of interconception services provided to Healthy Start Clients from 62,509 (2015: Well Family System) to 75,984.

4. By 2026, increase the percentage of pregnant women who had a prenatal screen from 65.6 percent (2020: Health Management System) to 70.3%.

5. By 2026, increase percent of new mothers in Florida who received information about how to prepare for a healthy pregnancy and baby prior to pregnancy from 22.8 percent (FL-PRAMS: 2014) to 30 percent.

6. By 2026, decrease the pregnancy-related mortality ratio from 19.8 per 100,000 live births (2019: FL MMRC) to 15.0 per 100,000 live births.

7. By 2026, decrease the number of women who experience postpartum depressive symptoms following a live birth from 13.0 percent (2019: FL-PRAMS) to 10.2 percent.

7. By 2026, decrease the number of women who experience postpartum depressive symptoms following a live birth from 13.0 percent (2019: FL-PRAMS) to 10.2 percent.

9. By 2026, Decrease the number of infants diagnosed with neonatal abstinence syndrome from 1,375 (2018:FLCHARTS) to 1,181.

Strategies
1. Implement a statewide syphilis campaign in collaboration with the Division of Disease Control and Health Protection/Bureau of Communicable Diseases to reduce the number of syphilis cases.
2. Provide education on the roles of County Health Departments.
3. Provide interconception services to Healthy Start clients on Medicaid from 60 days to 12 months as a result of Florida's extension of Medicaid postpartum coverage.
4. Develop and implement an electronic prenatal screening system to reduce barriers to the existing process and decrease the number of days from identification of risk to assessment.
4a. Educate stakeholders (e.g., providers, Healthy Start Coalitions, partnering agencies, pregnant woman) on the purpose and process for the electronic prenatal screening system.
5. Increase the number of referrals to the Coordinated Intake and Referral system that connects pregnant women, interconception women, and families of children under the age of three to services.
6. Partner with Count the Kicks for a statewide stillbirth prevention and awareness program that teaches expectant parents the method for, and importance of, tracking fetal movement daily during the third trimester of pregnancy.
7. Contract with Healthy Start Coalitions to conduct perinatal screening to prenatal participants, interconception women, and mothers of infants and toddlers referred to Healthy Start.
7a. Contract for services for the Perinatal Mental Health Program, BH IMPACT, to improve the identification and treatment of pregnant and postpartum women who experience mental health and substance use disorders.
8. Establish telehealth minority maternity care pilot programs to expand the capacity for positive maternal health outcomes in racial and ethnic minority populations in coordination with the Office of Minority Health and Health Equity.
8a. Conduct maternal mortality campaign for awareness and reduction.
8b. Provide fiscal support and technical assistance to the MCH Healthy Babies Initiative to identify, evaluate, prioritize, and address health disparities through the provision of evidence-based interventions.
9. Contract with the FPQC to work with providers, hospitals, and other stakeholders to improve identification, clinical care, and coordinated treatment/support for pregnant women with opioid use disorder and their infants.
9a. Collaborate with the Florida Department of Children and Families, Healthy Start Coalitions, Nurse Family Partnership, and Healthy Families Florida in developing Plan of Safe Care for pregnant women with substance use disorder.

ESMs	Status
ESM 1.1 - The number of interconception services provided to Healthy Start clients	Active

NOMs

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

NOM 3 - Maternal mortality rate per 100,000 live births

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

NOM 5 - Percent of preterm births (<37 weeks)

NOM 6 - Percent of early term births (37, 38 weeks)

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.2 - Neonatal mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy

NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

State Action Plan Table (Florida) - Women/Maternal Health - Entry 2

Priority Need

Promote tobacco cessation to reduce adverse birth outcomes and secondhand smoke exposure to children.

NPM

NPM 14.1 - Percent of women who smoke during pregnancy

Objectives

1. By 2026, increase the number of referrals to Tobacco Free Florida Quit Services from 20,533 (DOH-Tobacco-Free Florida Quit Line Providers: 2016) to 25,500.

2. By 2026, decrease the percentage of women who smoked cigarettes in the three months prior to becoming pregnant from 9.1 percent (2019: FL-PRAMS) to 7.1 percent.

3. By 2026, decrease the percentage of women who smoked during pregnancy from 4.1 percent (2020: FLCHARTS) to 2.7 percent.

Strategies

1. Refer clients and their families in the Healthy Start program to free and proven effective services to help them quit using all tobacco products, including e-cigarettes in collaboration with the Bureau of Tobacco Free Florida. This includes the suite of Quit Your Way services that include phone quit, web coach, text and email quit support.

2. Provide free resources to educate families and teenagers about the health hazards of vaping by visiting EndTeenVapingFL.gov.

3. Train Healthy Start Coalitions skills that include motivational interviewing that can increase client utilization of cessation through partnership with the Bureau of Tobacco Free Florida and Area Health Education Centers (AHEC).

3a. Partner with Tobacco Free Florida community intervention providers in each county to educate Healthy Start clients on the dangers of secondhand smoke and assist in implementation of policies that protect all people, especially children, from exposure.

ESMs	Status
ESM 14.1.1 - The number of Smoking Cessation Reduction in Pregnancy Treatment (SCRIPT) services provided to Healthy Start clients	Active

NOMs

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

NOM 3 - Maternal mortality rate per 100,000 live births

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

NOM 5 - Percent of preterm births (<37 weeks)

NOM 6 - Percent of early term births (37, 38 weeks)

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.2 - Neonatal mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

Women/Maternal Health - Annual Report

Using a broader, more inclusive, and more realistic way to impact women's health and the health of the entire community, the FDOH has reassessed, updated, and realigned targeted strategies and objectives to address the state priority to improve access to health care for women and to improve preconception and interconception health, specifically women who face significant barriers to better health.

The national performance measure selected for this priority was NPM 1: Percent of women with a past year preventive medical visit. The FDOH has identified objectives and strategies to improve the health of Florida's women.

Pregnancy provides an opportunity to promote women's overall health and establish a strong foundation for children's health. A child's health during the prenatal, infancy, and early childhood periods influences his or her health later in life. The FDOH, through the state's Healthy Start program, provides care coordination services to pregnant women at risk for preterm or low birth weight infants. This is an optimal opportunity to ensure pregnant women receive prenatal care, including screening for conditions such as gestational diabetes, monitoring for potential complications, and education to encourage healthy behaviors such as smoking cessation and healthy eating.

Preconception health provides opportunities to promote the health of women before they become pregnant through improved access to health care, whether it be through an actual well-care visit or through services offered through the FDOH's other programs such as diabetes prevention and breast or cervical cancer screening. With half of all U.S. pregnancies unplanned, preconception health and health care are important for all people of reproductive age. Primary carefor women encompasses screening and assessment, health promotion and counseling, and brief interventions or referrals for additional services when warranted.

The FDOH will continue to build and strengthen state and community partnerships to develop comprehensive systems of care for women and use data to inform program development and policy change. Partnerships between Florida's Title V MCH program and other state and community agencies such as Florida's Medicaid agency; providers; home visiting programs including the MIECHV program; local health departments; and community health centers are critical to developing and advancing comprehensive preconception health efforts at the state and local level as well as the overall system of care for women.

Strong state leadership and an ongoing structure such as the FDOH's State Health Improvement Plan, the integrated county health departments, and the Florida Perinatal Quality Collaborative are core elements of sustained success and the ability to make improvements to policies, programs, and services for not only low-income women and their families but allwomen and families in Florida.

The FDOH will continue to use Title V funding to provide interconception care (ICC) through Florida's Healthy Start Program. In addition, to reach women before their first pregnancy, the FDOH's MCH Section will continue to partner with the Adolescent and Reproductive Health Section to implement a statewide project promoting preconception health and overall wellness targeted at adolescents.

Title V funding will continue to be provided through Schedule C and a Statement of Work to all 67 county health departments to provide services to women. These services may include well-woman preventative health visits; prenatal care; education for chronic disease management and prevention for pregnant women; preconception health counseling; reproductive health services; and dental care services for pregnant women as well as children (with an emphasis on children up to age six). County health departments also engage in activities that promote access to care, health literacy, andcommunity engagement and/or establishment of policies that positively influence social and economic conditions to address the social determinants of health.

In 2019, the stillbirth rate in Florida was 6.8 per 1,000 deliveries (FLCHARTS). Women who are black experience stillbirth at twice the rate of the general pregnant population. The FDOH will continue to use Title V funding on the Count the Kicks campaign. Count the Kicks is an evidence based stillbirth prevention campaign that teaches moms to count their babies' movements daily during her third trimester of pregnancy and to call her obstetric provider if she noticesa change in what is normal for her baby. Count the Kicks materials are available at no cost for Florida providers. The FDOH and Count the Kicks will be implementing a billboard campaign over the next year and offering more trainings to home visitors and health care providers.

The FDOH's MCH Section will continue to contract with the Florida Pregnancy Care Network to implement the Florida Pregnancy Support Services Program. This program is a network of nonprofit crisis pregnancy centers that provide support and assistance to women, men, and their families who may be facing an unplanned pregnancy. Services include free

pregnancy tests, peer counseling, and referrals; and most of the centers offer classes on pregnancy, childbirth, parenting, and personal finance management. The FDOH provides technical support to the program on evidence-based models and promotes services that are available from the Florida Association of Healthy Start Coalitions and county health departments as a referral source. The program also provides wellness services including well woman exams and health screenings for non-pregnant women 18 and older and STI testing.

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- Maintaining provider participation and engagement in the program. Expand mental health and substance abuse referral networks in the regions. Increase statewide maternal mental health resources and capacity.
- Increasing access to screening, referral, and treatment for women in rural and non-rural areas through telehealth resources.
- Training community mental health providers in evidence-based psychotherapy and management of perinatal mental

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There are large populations of Floridians, including many children, for whom tobacco use and exposure to secondhand smoke is a daily fact of life. These groups are disproportionately impacted by the health burden of tobacco use, which is especially high among certain subpopulations, including racial and ethnic minorities, low-income individuals, the LGBT community, and those with mental health conditions.

For example, smoking among all racial ethnic groups adults in Florida has declined since 2012, but smoking among non-Hispanic blacks and Hispanics in Florida has not seen a substantial decline. Lower income cigarette smokers suffer more from diseases caused by smoking than smokers with higher incomes. Tobacco use is higher among Florida adults who are not heterosexual as compared to heterosexual adults. Adults reporting poor mental health have higher smoking rates than adults reporting good mental health.

The FDOH will continue researching ways to provide postpartum cessation or relapse support in addition to the SCRIPT program. The evaluation of SCRIPT found that SCRIPT efficacy has only been examined through 90 days postpartum, potentially falling short of long-term support for mothers postpartum. By incorporating a postpartum support program, women in the interconception period are reached as well.

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Family planning providers across the state will continue to screen their clients for tobacco use and provide information on Florida's Quit Your Way. The FDOH Bureau of Tobacco Free Florida has implemented a secondhand smoke campaign targeted toward pregnant women. will continue to encourage all health care providers to counsel women of childbearing age and all pregnant women on the dangers of tobacco use as well as the dangers of secondhand smoke. The FDOH will continue to monitor the Healthy Start Standards and Guidelines to ensure that resources and guidance are current. The FDOH is committed to helping Florida residents reach their fullest health potential by living tobacco free lives.

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The MCH Section is implementing a comprehensive maternal mortality awareness and reduction campaign. This will include promotion of the BH IMPACT program, a mother empowerment component, and a C-Section reduction and education piece.

In addition to initiatives previously described, the FDOH will continue to support staff with Title V funding to provide oversight and monitoring of the following contracts to address maternal and women's health priorities:

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The FDOH was awarded additional funding through the CDC's Preventing Maternal Deaths: Supporting Maternal Mortality. With this funding, the FDOH has plans to look more closely at pregnancy associated deaths related to substance use and mental health disorders. There has been a rise in these types of deaths in Florida. While it does appear that these deaths are not pregnancy related, the FDOH wants to examine this data more closely to determine what actions or programs can be implemented to prevent these deaths from occurring.

Finally, the MCH Section is working with FDOH information technology staff to update the universal prenatal risk screen to an electronic format. Currently the prenatal screen is completed on paper. By transitioning to an fully electronic process, the FDOH anticipates an increase in completed screens and a decrease in the time between screen completion and entry into services. In conjunction with this upgrade, the FDOH will be kicking off a prenatal screen campaign to raise awareness of the screen and provide more education and technical assistance in completing the screen.

Women/Maternal Health - Application Year

Using a broader, more inclusive, and more realistic way to impact women's health and the health of the entire community, the FDOH has reassessed, updated, and realigned targeted strategies and objectives to address the state priority to improve access to health care for women and to improve preconception and interconception health, specifically women who face significant barriers to better health.

The national performance measure selected for this priority was NPM 1: Percent of women with a past year preventive medical visit. The FDOH has identified objectives and strategies to improve the health of Florida's women.

Pregnancy provides an opportunity to promote women's overall health and establish a strong foundation for children's health. A child's health during the prenatal, infancy, and early childhood periods influences his or her health later in life. The FDOH, through the state's Healthy Start program, provides care coordination services to pregnant women at risk for preterm or low birth weight infants. This is an optimal opportunity to ensure pregnant women receive prenatal care, including screening for conditions such as gestational diabetes, monitoring for potential complications, and education to encourage healthy behaviors such as smoking cessation and healthy eating.

Preconception health provides opportunities to promote the health of women before they become pregnant through improved access to health care, whether it be through an actual well-care visit or through services offered through the FDOH's other programs such as diabetes prevention and breast or cervical cancer screening. With half of all U.S. pregnancies unplanned, preconception health and health care are important for all people of reproductive age. Primary carefor women encompasses screening and assessment, health promotion and counseling, and brief interventions or referrals for additional services when warranted.

The FDOH will continue to build and strengthen state and community partnerships to develop comprehensive systems of care for women and use data to inform program development and policy change. Partnerships between Florida's Title V MCH program and other state and community agencies such as Florida's Medicaid agency; providers; home visiting programs including the MIECHV program; local health departments; and community health centers are critical to developing and advancing comprehensive preconception health efforts at the state and local level as well as the overall system of care for women.

Strong state leadership and an ongoing structure such as the FDOH's State Health Improvement Plan, the integrated county health departments, and the Florida Perinatal Quality Collaborative are core elements of sustained success and the ability to make improvements to policies, programs, and services for not only low-income women and their families but allwomen and families in Florida.

The FDOH will continue to use Title V funding to provide interconception care (ICC) through Florida's Healthy Start Program. In addition, to reach women before their first pregnancy, the FDOH's MCH Section will continue to partner with the Adolescent and Reproductive Health Section to implement a statewide project promoting preconception health and overall wellness targeted at adolescents.

Title V funding will continue to be provided through Schedule C and a Statement of Work to all 67 county health departments to provide services to women. These services may include well-woman preventative health visits; prenatal care; education for chronic disease management and prevention for pregnant women; preconception health counseling; reproductive health services; and dental care services for pregnant women as well as children (with an emphasis on children up to age six). County health departments also engage in activities that promote access to care, health literacy, andcommunity engagement and/or establishment of policies that positively influence social and economic conditions to address the social determinants of health.

In 2019, the stillbirth rate in Florida was 6.8 per 1,000 deliveries (FLCHARTS). Women who are black experience stillbirth at twice the rate of the general pregnant population. The FDOH will continue to use Title V funding on the Count the Kicks campaign. Count the Kicks is an evidence based stillbirth prevention campaign that teaches moms to count their babies' movements daily during her third trimester of pregnancy and to call her obstetric provider if she noticesa change in what is normal for her baby. Count the Kicks materials are available at no cost for Florida providers. The FDOH and Count the Kicks will be implementing a billboard campaign over the next year and offering more trainings to home visitors and health care providers.

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Perinatal/Infant Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2018	6.1	NPM 3
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2018	6.0	NPM 3 NPM 4 NPM 5
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2018	4.1	NPM 3
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2018	2.0	NPM 4 NPM 5
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2018	218.9	NPM 3
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2018	87.6	NPM 4 NPM 5

National Performance Measures

NPM 3 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)
Indicators and Annual Objectives

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	78.9	78.1
Numerator	2,737	2,492
Denominator	3,469	3,191
Data Source	Florida CHARTS	Florida CHARTS
Data Source Year	2019	2020
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	79.4	80.0	80.5	81.0	81.6	82.1

Evidence-Based or –Informed Strategy Measures

ESM 3.1 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Measure Status:	Active

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	2019	2020
Annual Objective		
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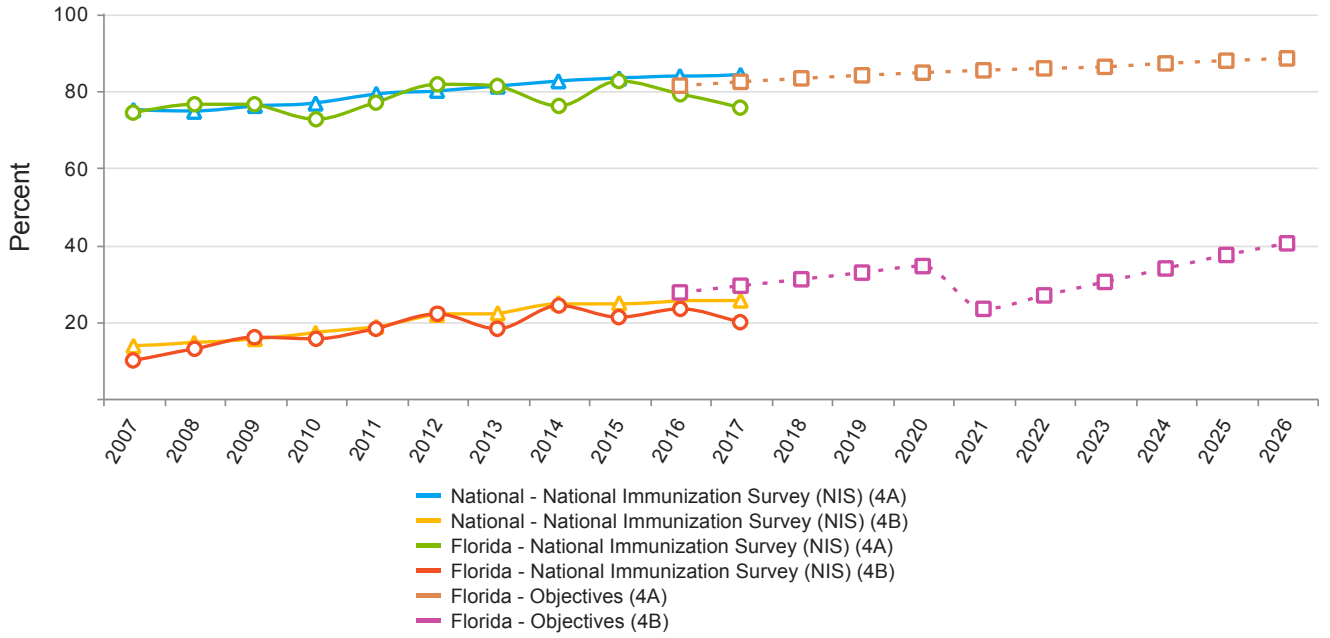
NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months Indicators and Annual Objectives



NPM 4A - Percent of infants who are ever breastfed

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	81.3	82.3	83.2	84	84.7
Annual Indicator	81.1	76.1	82.6	79.2	75.6
Numerator	171,099	155,283	190,605	168,560	157,351
Denominator	210,888	203,992	230,680	212,751	208,001
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016	2017

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	85.3	85.8	86.2	87.1	87.8	88.4

NPM 4B - Percent of infants breastfed exclusively through 6 months

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	27.7	29.4	31.1	32.8	34.5
Annual Indicator	18.4	24.3	21.3	23.4	19.9
Numerator	37,940	49,156	47,798	48,426	39,516
Denominator	206,047	201,974	224,023	206,578	198,423
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016	2017

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	23.4	26.9	30.4	33.9	37.4	40.4

Evidence-Based or –Informed Strategy Measures

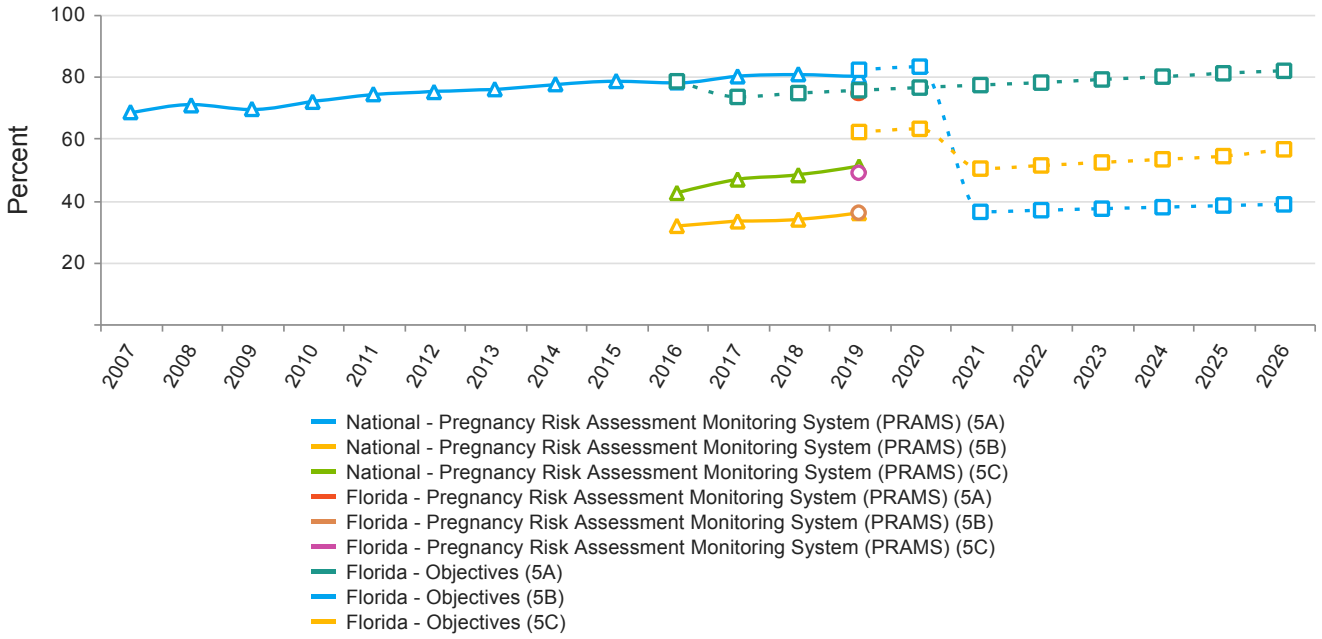
ESM 4.1 - The number of Florida hospitals achieving the Baby Steps to Baby Friendly hospital designation.

Measure Status:	Active

State Provided Data				
	2017	2018	2019	2020
Annual Objective			19	20
Annual Indicator			26	26
Numerator				
Denominator				
Data Source			Baby-Friendly USA	Baby-Friendly USA
Data Source Year			2019	2020
Provisional or Final ?			Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	27.0	29.0	30.0	32.0	33.0	37.0

NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding Indicators and Annual Objectives



NPM 5A - Percent of infants placed to sleep on their backs

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2020
Annual Objective	76.3
Annual Indicator	74.3
Numerator	153,404
Denominator	206,486
Data Source	PRAMS
Data Source Year	2019

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective	78.3	73.3	74.5	75.4	76.3
Annual Indicator	69.5	74	74	72.1	74.3
Numerator					
Denominator					
Data Source	FL PRAMS Data	FL PRAMS Data	FL PRAMS	FL PRAMS	FL PRAMS
Data Source Year	2014	2015	2015	2018	2019
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	77.1	77.9	78.9	79.8	80.9	81.7

NPM 5B - Percent of infants placed to sleep on a separate approved sleep surface

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2020
Annual Objective	83
Annual Indicator	36.0
Numerator	71,406
Denominator	198,188
Data Source	PRAMS
Data Source Year	2019

State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			82	83
Annual Indicator	78	35.4	35.3	35.3
Numerator				
Denominator				
Data Source	FL PRAMS Data	FL PRAMS Data	FL PRAMS	FL PRAMS
Data Source Year	2015	2018	2018	2019
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	36.3	36.8	37.3	37.8	38.3	38.7

NPM 5C - Percent of infants placed to sleep without soft objects or loose bedding

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2020
Annual Objective	63
Annual Indicator	48.8
Numerator	96,651
Denominator	197,982
Data Source	PRAMS
Data Source Year	2019

State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			62	63
Annual Indicator	60	42.3	48.2	48.2
Numerator				
Denominator				
Data Source	FL PRAMS Data	FL PRAMS	FL PRAMS	FL PRAMS
Data Source Year	2015	2018	2018	2019
Provisional or Final ?	Provisional	Final	Final	Final

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	50.2	51.2	52.2	53.2	54.2	56.4

Evidence-Based or –Informed Strategy Measures

ESM 5.1 - The number of birthing hospitals that are Safe Sleep Certified

Measure Status:	Active

State Provided Data				
	2017	2018	2019	2020
Annual Objective			17	19
Annual Indicator			10	23
Numerator				
Denominator				
Data Source			Cribs for Kids	Cribs for Kids
Data Source Year			2019	2020
Provisional or Final ?			Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	25.0	27.0	29.0	31.0	33.0	37.0

State Action Plan Table

State Action Plan Table (Florida) - Perinatal/Infant Health - Entry 1	
Priority Need	
Promote breastfeeding to ensure better health for infants and children and reduce low food security.	
NPM	
NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months	
Objectives	
1. By 2026, increase the number of Baby-Friendly Hospitals from 20 (2020) to 30.	
2. By 2026, increase the percentage of women who initiate breastfeeding from 86.0 percent (2019: FL CHARTS) to 90.4 percent.	
3. By 2026, increase the percentage of women who breastfed exclusively through 6 months from 29.4 percent (2017:NIS) to 33.4 percent.	
Strategies	
1. Continue to encourage hospitals to establish policies and protocols in support of breastfeeding and becoming a Baby Steps to Baby Friendly hospital or a Florida Breastfeeding Coalition's Quest for Quality Maternity Care Award recipient though the Florida Healthy Babies Initiative.	
1a. Support the Bureau of Chronic Disease in their efforts to provide technical assistance to hospitals, work places, and early care and education program to implement breastfeeding policies and programs by partnering with the Florida Breastfeeding Coalition and the Florida Child Care Food Program.	
2. Contract with Healthy Start Coalitions to provide breastfeeding support and education to Healthy Start clients.	
2a. Assess existing lactation rooms at the FDOH to identify enhancements to support breastfeeding/pumping in the workplace.	
3. Partner with the Pacify program to increase access to professional lactation support through telelactation services.	
ESMs	**Status**
ESM 4.1 - The number of Florida hospitals achieving the Baby Steps to Baby Friendly hospital designation.	Active

NOMs

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

State Action Plan Table (Florida) - Perinatal/Infant Health - Entry 2

Priority Need

Promote activities to improve the health of children and adolescents and promote participation in extracurricular and/or out-of- school activities in a safe and healthy environment.

NPM

NPM 3 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Objectives

By 2026, increase the number of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU) from 78.9 percent (2017: FLCHARTS) to 82.1 percent.

Strategies

1. Contract with the Florida Perinatal Quality Collaborative (FPQC) to implement the self-designated and verified maternal and newborn hospital level of care project.

1a. Contract with the FPQC for the monitoring maternal health care quality project.

1b. Promote the current regional perinatal intensive care centers program.

1c. Conduct maternal mortality campaign for awareness and reduction.

1d. Participate in the Agency for Healthcare Administration’s Birth outcomes workgroup.

1e. Continue quarterly pregnancy associated mortality review committee meetings to review maternal mortality and morbidity and make recommendations for system change.

ESMs	Status
ESM 3.1 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)	Active

NOMs

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.2 - Neonatal mortality rate per 1,000 live births

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

State Action Plan Table (Florida) - Perinatal/Infant Health - Entry 3

Priority Need

Promote safe and healthy infant sleep behaviors and environments including improving support systems, and daily living conditions that make safe sleep practices challenging.

NPM

NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Objectives

1. By 2026, reduce percent of black mothers in Florida whose infant sleeps in bed with a parent or anyone else from 38.6 percent (2019: FL-PRAMS) to 35.3 percent.

2. By 2026, increase percent of black mothers in Florida who placed their infant on their back to sleep from 60.3 percent (2019) to 66.4 percent.

Strategies

1a. Promote safe sleep behaviors among families and infant caregivers with an emphasis on disparate populations through the Healthy Start program.

1b. Implement a statewide Safe Sleep Certification model in birthing hospitals located in Florida.

1c. Using the Florida Healthy Babies Initiative, inventory and evaluate safe sleep activities currently implemented statewide.

2. Partner with national organizations, such as the National Institute of Child Health Quality, to promote safe sleep initiatives and support local service providers (e.g. hospitals and social services) that interact with high risk populations.

2a. Provide infant safe sleep education through partnership with the Cribs for Kids organization.

ESMs	Status
ESM 5.1 - The number of birthing hospitals that are Safe Sleep Certified	Active

NOMs

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

Safe infant sleep and breastfeeding are significant protective factors against infant mortality. From 2010-2019 (the most recently available data), breastfeeding initiation, for all races, increased from 80.1 percent to 89.8 percent. During this period, the gap between the breastfeeding percentages for non-Hispanic black and white infants decreased. However, the breastfeeding initiation percentages for non- Hispanic black infants are still the lowest of the racial/ethnic groups examined. In 2019, the percentage was 78.1 percent for non-Hispanic black, 86.4 percent for non-Hispanic white, and 90.3 percent for Hispanic infants. According to the CDC, the 2017 percentage of exclusive breastfeeding at three months in Florida (41.1 percent) is lower than in the nation (46.9 percent).

In Florida, sudden infant death syndrome (SIDS) consistently ranks in the top four leading causes of post-neonatal infant death. In 2019, the resident SIDS death rate was approximately 0.3 per 1,000 live births in Florida. However, black infants experience rates that are consistently two times higher than the rates among other ethnic groups. (0.7)

The FDOH engaged in several activities through a variety of public-private partnerships to improve rates of breastfeeding initiation and duration. With Title V funding, the Florida Healthy Start Coalitions and the county health departments partner to provide needed services including prenatal care, support services, and breastfeeding education and support to all participating pregnant women. Services provided to pregnant women encourage breastfeeding in the early postpartum period. These services also provide anticipatory guidance and support to prevent breastfeeding problems and address barriers to breastfeeding. Breastfeeding education and services provided to postpartum women promote the continuation and exclusivity of breastfeeding and enable women to overcome any perceived or actual breastfeeding problems.

Florida's WIC Program provides peer counseling and breastfeeding support to women who qualify for WIC. The FDOH plans to explore alternative breastfeeding support options for women who need breastfeeding support and do not qualify for WIC.

Safe Sleep Initiatives

Florida continued the Florida Safe Sleep Hospital Certification Project, a partnership with county health departments to recruit birthing hospitals to complete the requirements needed to achieve Safe Sleep Certification from the Cribs for Kids Organization. There are currently 23 hospitals certified through the Safe Sleep Certification program. These hospitals have completed steps including implementing a Safe Sleep policy. Annual reports are submitted to Cribs for Kids on educational activities and staff compliance. The top eight counties in Florida with elevated sleep related death rates have been identified. The FDOH reached out to them directly to engage them in enhanced safe sleep activities.

To help reduce SUID-related deaths, the American Academy of Pediatrics (AAP) published updated safe sleep recommendations in 2016 promoting supine positioning, the use of a firm sleep surface, room-sharing, no bed sharing, and breastfeeding among others. Health care providers and community partners, such as Healthy Start staff, continue to promote and educate infant caregivers on these recommendations during direct interactions.

In January, 2020, a promising safe sleep initiative, *Sleep Baby Safely*, was implemented by the Child Abuse Death Review Committee in Duval County. This initiative was supported with funding from the Title V Maternal and Child Health Block Grant. *Sleep Baby Safely* includes training at all birthing hospitals and facilities, providing labor and delivery nurses and hospital birthing staff a framework for providing face-to-face safe sleep education to the new parents of each baby born. The initiative also ensures that along with face-to-face education, each new parent is also provided a Welcome Baby Bag including a onesie, infant sleep sack, nightlight, diaper tote, and outlet covers, all imprinted with the ABCs of safe sleep messaging (Alone, Back, Crib), as well as a Safe Sleep baby book and other sleep-related educational materials. Prior to the implementation of this initiative, Duval County reported an average of 2-3 infant deaths associated with unsafe sleep practices each month. During the first 8 months of implementing this initiative, there has been one incident of sleep-related infant death in Duval County. While the loss of one child to unsafe sleep is too many, the significant decrease in infant death across the county demonstrates the exceptional efficacy of this initiative.

The FDOH continues to participate in the National Institute for Children's Health Quality's (NICHQ) five-year project from July 2017 to July 2022, "National Action Partnership to Promote Safe Sleep Improvement and Innovation Network (NAPPSS-INN): Making Safe Infant Sleep and Breastfeeding a National Norm. "Within this role, Florida's data was analyzed to identify birthing hospitals that could have the greatest impact on improving breastfeeding and safe sleep behaviors and these birthing hospitals were invited to participate. After interested hospitals completed competitive applications, one birthing hospital participated in the first phase of the project and another hospital in the second phase. Florida's Community of Practice was created to include a group of leaders from public and private sectors in the state. The group included members from the Executive Office of the Governor, March of Dimes, the Florida Perinatal Quality Collaborative, the Florida SIDS Alliance, and the

American College of Obstetrics & Gynecology. Under this leadership, an asset map and SMART objectives were completed for the group to follow in their respective work.

As a component of Florida's Healthy Babies Initiative, all 67 county health departments are given Title V funding specifically to address factors that contribute to infant mortality in their communities. This includes safe sleep. County health departments submitted action plans that were reviewed by subject matter experts in the program offices through a lens of identifying proposed strategies and best practices that could be applied and have statewide impact. The most commonly proposed strategies and themes identified in the counties' local plans were breastfeeding, smoking reduction among pregnant women, safe sleep, and increased WIC access and utilization. Multiple safe sleep programs in Florida communities provided safe sleep information, cribs, pack and plays, and infant onesies with safe sleep messages this past year,

The FDOH conducted a health problem analysis of contributing factors to SIDS and developed a logic model at the state level to address these risk factors with outcome measures to assess strategy effectiveness. These two documents have been instrumental in the development of a state work plan to address SIDS.

Breastfeeding Initiatives

Florida's Enhanced Breastfeeding Project is addressing health inequities to mitigate breastfeeding disparities among vulnerable populations including rural, minority, and low socioeconomic communities. There are several county health departments implementing two to three evidenced-based strategies within their local communities as part of the project. Qualitative review of hospital success stories and anecdotal evidence have shown that the BSBF project has also served as a catalyst for community engagement. New breastfeeding support groups in rural areas and local breastfeeding coalitions have been established as a result of the project.

Duration of breastfeeding is an identified concern, with known contributing factors including lack of breastfeeding support in the workplace. Having access to proper equipment, such as an electric breast pump for mothers returning to work, is essential to breastfeeding success. A statewide commitment to give babies the best start is evidenced by efforts from Florida's Agency for Health Care Administration. As of June 20, 2016, Florida Medicaid's Durable Medical Equipment Fee Schedule covers breastpumps, demonstrating a commitment to promote the best nutrition and the best start for Florida's babies.

MCH epidemiology staff housed in the MCH Section perform analysis of FDOH programs impacting the MCH population. One study showed the receipt of breastfeeding peer counseling services are associated with increased breastfeeding initiation and duration. Additionally, the study showed that non-Hispanic black participants are less likely to initiate breastfeeding and continue to breastfeed at 6 months. To address this issue, the MCH program has updated Florida's Healthy Start Standards and Guidelines and provider competencies to include the importance of personal, social, and cultural factors when providing breastfeeding education to clients.

Data from the 2019 Florida Pregnancy Risk Assessment Monitoring System (PRAMS) show that the percent of Florida women who initiate breastfeeding is higher, at 89.8 percent, than the Healthy People 2020 goal of 81.9 percent. However, duration drops quickly to 64.2 percent at 4+ weeks and to 54.8 percent at 12+ weeks. This survey is a valuable tool for recognizing trends and identifying a focus for breastfeeding promotion efforts. Survey data can be found at: http://www.floridahealth.gov/statistics-and-data/survey-data/pregnancy-risk-assessment-monitoring-system/

Perinatal/Infant Health - Application Year

The FDOH will continue participating in the statewide plan of safe care (POSC) workgroup. This workgroup brings together partners from other state agencies and organizations in Florida to address facilitating the POSC process in Florida. Part of this is the consideration that POSC will be completed prenatally. This is unique in that POSC are typically completed once a baby is born. By engaging moms during the prenatal period, there is a chance to get her assistance and treatment prior to delivery helping to ensure a better birth outcome.

The FDOH will also continue it's participation in the Agency for Health Care Administration's birth outcomes workgroups. These workgroups bring together not only state agencies, university and non-governmental partners, but also Medicaid managed care organizations. By having all interested parties at the table, interested parties are able to discuss and address actionable items.

The FDOH will continue to promote objectives and strategies to increase the number of breastfed infants as well as the duration they are fed breast milk. Breastfeeding promotion strategies have been incorporated into several initiatives through various community settings such as hospitals and childcare facilities. This will continue to be carried out through active partnerships between the county health departments and their communities, Florida's Healthy Start Coalitions, and other partners and stakeholders.

To enhance our reach to the African-American community, we are designing a safe infant sleep and breastfeeding education toolkit for African-American Greek Organizations (sororities and fraternities) to share during their outreach community activities. The toolkit includes the official AAP recommendations, data-related content on safe sleep and breastfeeding, developing partnerships with other organizations, event ideas, and tips on evaluating the effectiveness of their community event.

The FDOH will continue to participate in the National Institute for Children's Health Quality's (NICHQ) National Action Partnership to Promote Safe Sleep Improvement and Innovation Network (NAPPSS-IIN) Initiative. The purpose of NAPPSS-IIN is to make safe infant sleep and breastfeeding a national norm. The project is a five-year cooperative agreement running from July 2017 to July 2022. Through this effort, the FDOH, with the support of NICHQ, will continue partnerships within Florida communities to develop, and implement a safe infant sleep and breastfeeding safety bundle within hospitals, child care, and social services settings.

The objective of the project is to move from campaigns to conversations in promoting safe infant sleep and breastfeeding and translating evidence-based practices into "safety bundles" to improve the processes of care and patient outcomes in safe sleep and breastfeeding. Specifically, the project aims to increase infant caregiver adoption of safe infant sleep practices as recommended by the American Academy of Pediatrics, as well as breastfeeding, by empowering champions for these protective behaviors within systems that serve at-risk families.

The data that we will use for tracking the third element of this national performance measure, NPM 5: A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding, are currently being collected during the 2016–2019 Phase VIII of the Florida Pregnancy Risk Assessment Monitoring System (PRAMS). Florida has no other local data source that would facilitate the assessment of this measure.

The MCH Section will continue the Florida Healthy Babies initiative. Guidance for the coming year has been streamlined and more defined. County health departments reported confusing surrounding the reporting of metrics for the program. To address this, a new scope of work has been revised that helps clarify the goals of the program and how the goals align with the Title V Block Grant, the FDOH Strategic Plan, the State Health Improvement Plan and the Healthy People 2030 goals. We anticipate seeing more consistent reporting and more local involvement.

More than ever the FDOH feels they are poised to implement the telelactation breastfeeding support program, Pacify. Pacify's services empower women to connect with International Board-Certified Lactation Consultants (IBCLCs) through two-way video on personal devices such as smartphones and tablets. Live video support from IBCLCs is available 24/7, in English and Spanish, through the Pacify mobile application. Increasing access to IBCLCs is an evidence-based strategy for increasing rates of breastfeeding, and the provision of telelactation services have effectively improved outcomes in several public health programs.

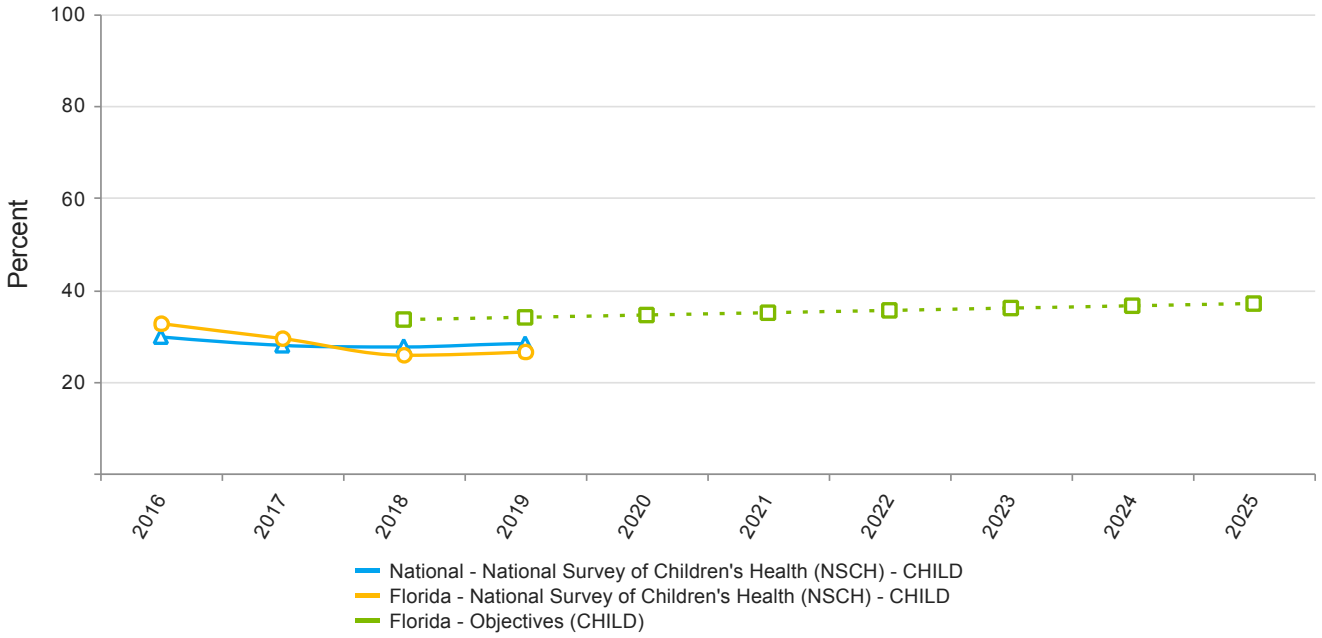
Child Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	91.3 %	NPM 8.1
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	NSCH-2018_2019	17.8 %	NPM 8.1
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	WIC-2018	13.3 %	NPM 8.1
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	YRBSS-2019	14.0 %	NPM 8.1

National Performance Measures

NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day
Indicators and Annual Objectives



Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CHILD					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			33.5	34	34.5
Annual Indicator		32.5	29.4	25.8	26.3
Numerator		428,914	394,477	364,148	361,483
Denominator		1,321,058	1,341,890	1,409,470	1,375,329
Data Source		NSCH-CHILD	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	35.0	35.5	36.0	36.5	37.0	37.5

Evidence-Based or –Informed Strategy Measures

ESM 8.1.1 - The cumulative total of Florida school districts that have ever been awarded the evidence-based Florida Healthy School District recognition.

Measure Status:	Active

State Provided Data				
	2017	2018	2019	2020
Annual Objective			54	55
Annual Indicator			49	49
Numerator				
Denominator				
Data Source			Safe and Healthy Schools Florida	Safe and Healthy Schools Florida
Data Source Year			2019	2020
Provisional or Final ?			Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	56.0	57.0	58.0	59.0	60.0	61.0

State Performance Measures

SPM 2 - The percentage of low-income children under age 21 who access dental care.

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		37.4	38.9	40.4	41.9
Annual Indicator	35.9	37.4	38.5	48.7	31.9
Numerator	986,425	1,037,798	1,045,121	755,818	842,727
Denominator	2,745,598	2,774,485	2,716,229	1,551,734	2,639,833
Data Source	Florida Agency for Health Care Administration	Florida Agency for Health Care Administration	Florida Agency for Health Care Administration	Florida Agency for Health Care Administration	Florida Agency for Health Care Administration
Data Source Year	2016	2017	2018	2017/2018	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	43.4	44.9	46.4	47.9	49.4	50.9

SPM 3 - The percentage of parents who read to their young child age 0-5 years

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		45.1	34.7	35.2	35.7
Annual Indicator	42.6	34.2	32.9	32.1	27.4
Numerator	545,146	435,455	396,388	384,878	369,850
Denominator	1,279,782	1,273,260	1,204,876	1,198,761	1,347,822
Data Source	2011-12 National Survey of Children's Health	2016 National Survey of Child Health	2016 National Survey of Child Health	2017-18 National Survey of Child Health	2018-19 National Survey of Child Health
Data Source Year	2011-2012	2016	2016-2017	2017-2018	2018-2019
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	36.2	36.7	37.2	37.7	38.2	38.7

State Action Plan Table

State Action Plan Table (Florida) - Child Health - Entry 1

Priority Need

Promote activities to improve the health of children and adolescents and promote participation in extracurricular and/or out-of- school activities in a safe and healthy environment.

NPM

NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Objectives

1. By December 31, 2021, increase the number of schools ever achieving the Healthier US Schools Challenge award from 507 (2016) to 800.

2. By December 31, 2021, increase the percentage of Florida's population within one mile of bike lane and/or shared use paths from 42 percent (2017) to 45 percent.

3. By June 30, 2020, increase the number of Florida counties where registered school nurses are implementing Healthy Lifestyle Interventions based on the 5210 programs from eight counties to four. The 5210 program is based on five servings of fruits and vegetables, less than two hours of recreational screen time, one hour or more of physical activity and zero sweetened drinks per day.

4. By June 30, 2019, increase the percentage of body mass index (BMI) intervention screening referrals for students at or above the 95th percentile that results in students receiving services from a healthcare provider from 31.6 percent (2016-17 baseline) to 36.6 percent. (This measure is the sum of completed referrals to healthcare providers and completed Healthy Lifestyle interventions by registered school nurses.)

5. Increase by 10 percent the number of Florida counties (school districts) that apply for recognition as a Florida Healthy District for the 2019-21 period compared to the number of districts that applied for the 2018-20 period.

Strategies

1. Promote/educate county school health programs about the use of the Healthy Lifestyle Intervention Individualized Healthcare Plan and coding this service data in the Department's Health Management System. Promote the Intervention on at least one School Health Services Program statewide conference call and during county School Health Program on-site monitoring meetings conducted by school health liaisons during the 2020–21 school year.

2. Promote/educate county school health programs on the requirements, application process, and benefits of becoming a Florida Healthy District on at least one School Health Services Program statewide conference call and during county school program onsite monitoring meetings conducted by school health liaisons during the 2020–21 school year.

3. Continue School Health Services Program involvement in the Florida Partnership for Healthy Schools (formerly the Florida Coordinated School Health Partnership), the Healthy District Collaborative, and the Interagency Collaborative by participating in meetings, conferences, and strategic planning.

4. Promote the Center for Disease Control and Prevention's Whole School, Whole Community, Whole Child approach by educating county school health programs on strategies to expand school health advisory committee representation, including student/parent involvement, on at least one School Health Services Program statewide conference call and during county school health program on-site monitoring meetings conducted by school health liaisons during the 2020–21 school year.

5. Promote policy, systems, and environmental approaches to increasing physical activity opportunities within the built environment for Floridians of all ages through coordination with local governments and stakeholders such as the Florida Department of Transportation, the Florida Recreation and Parks Association, East Central Florida Regional Planning Council, the Florida Department of Agriculture and Consumer Services, the Florida Department of Education and Florida Action for Healthy Kids.

ESMs	Status
ESM 8.1.1 - The cumulative total of Florida school districts that have ever been awarded the evidence-based Florida Healthy School District recognition.	Active

NOMs

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

State Action Plan Table (Florida) - Child Health - Entry 2

Priority Need

Improve dental care access for children and pregnant women

SPM

SPM 2 - The percentage of low-income children under age 21 who access dental care.

Objectives

1. By June 30, 2022 increase the number of low-income children under age 21 receiving a preventive dental service from a school-based sealant program from 107,570 children (SFY 2019-2020) to 112,949 children, an increase of 5 percent.

2. By September 30, 2022, increase the number of school-based sealant programs (internal or external) completing annual reports in FLOSS from 51 programs (SFY 2019-2020) to 57 programs.

3. By June 30, 2022, increase the number of schools reached by school-based sealant programs (internal or external) from 840 schools (SFY 2019-2020) to 882 schools, an increase of 5 percent.

Strategies

1. Partner with community agencies and organizations to improve data completeness related to statewide school-based sealant program efforts. Encourage participation in the FLOSS database and offer technical assistance as needed.

2. Increase the number of children participating in existing school-based sealant programs by implementing proven strategies to increase consent rate, such as educating parents, attending community events, and routine distribution of forms.

3. Improve the quality and sustainability of existing CHD school-based sealant programs by providing continued technical assistance and training and in-person site visits and program evaluations related to financial sustainability as requested.

State Action Plan Table (Florida) - Child Health - Entry 3

Priority Need

Address the social determinants of health that influence the relationship between health status and biology, individual behavior, health services, social factors, and policies.

SPM

SPM 3 - The percentage of parents who read to their young child age 0-5 years

Objectives

1. By 2026, increase the number of partners and local county health departments participating in the Reach Out and Read program from 100 in 2017 to 130 total sites.

2. By 2026, increase the percentage of parents who read to their your child age 0-5 years from 27.4% (2020: NSCH) to 38.7%.

Strategies

1. Partner with local health departments in their childhood immunization, dental clinics, and well-child visits to encourage reading using the Reach Out and Read model, where a health professional distributes books to children at a well-child visit and emphasizes key reading strategies to parents (example: the importance of reading aloud to a child daily).

Child Health - Annual Report

In 2020-2021, Florida's pre-kindergarten through 12th grade student population fell to 2.77 million students distributed across 67 geographically, socioeconomically and culturally diverse school districts. Preliminary data from local school health programs shows 663,223 students with health conditions, which included 24,221 with severe (life threatening) allergies, 109,565 with asthma, 9,590 with cardiac conditions, 6,937 with diabetes, 26,135 with mental-behavioral health conditions, and 13,872 with seizure disorders. Results from 264,142 body mass index screenings reflect 153,083 (57.95%) students fell in the healthy weight range, 8,842 (3.35%) in the underweight range, 44,486 (16.84%) in the overweight range and 57,731 (21.86%) in the obese range.

The FDOH's School Health Program continued its statewide leadership to ensure the provision of health services and health education to children in all of Florida's public and participating non-public schools. The program provided oversight and technical assistance to all 67 county School Health Programs, including county health departments, local education agencies, and their community partners, pursuant to Florida Statutes and Administrative Code.

Local county health departments, in collaboration with local education agencies and community partners, worked to ensure Florida's pre-kindergarten through 12th grade students had access to health services that assess, protect, and promote their health and ability to achieve their individual potential. During 2019-2020, the School Health Program performed 21 on-site programmatic monitoring visits, two vision service provider contract monitoring visits, and conducted four statewide programmatic conference calls.

The FDOH and the Florida Department of Education (DOE) partnered and promoted implementation of the Coordinated School Health approach in Florida public schools. The Bureau of Chronic Disease Prevention worked with DOE's Office of Healthy Schools to support the Florida Partnership for Healthy Schools Healthy School District self- assessment and recognition program. As part of this collaboration, the School Health Program reviewed and scored the health services section of each county's application. For 2020 Florida Partnership for Healthy Schools recognized 51 existing, new and renewed districts as Florida's Healthy School Districts 2020, 21 new school districts completed the self-assessment; previously recognized districts were given the option to extend their recognition for another year due to COVID-19. The FDOH and DOE's Bureau of Exceptional Education and Student Services collaborated on school entry immunization compliance activities and began planning for the development of an online training portal for registered school nurse trainings with continuing education that launched in 2019.

In addition, the School Health Program continued to develop partnerships with the Florida School Health Association and the Florida Association of School Nurses and presented programmatic updates at their 2019 annual conferences. Also, the program continued its commitment to support the National Association of School Nurses (NASN) initiative, Every Student Counts, by preparing 2020-202021 state-level data for a national standardized minimum dataset of key school health indicators.

Oral health is essential to general health and well-being. Poor oral health status correlates with other systemic diseases, such as diabetes, heart disease, respiratory disease, stroke, and preterm and low-weight births.Tooth decay (dental caries) is a transmissible, infectious oral disease resulting from an imbalance of multiple risk factors and protective factors over time. Though the prevalence and severity of tooth decay declined among school-aged children in recent years, it remains a significant problem in some populations, particularly among certain racial and ethnicgroups and low-income children.

Dental caries (tooth decay) remain the most common preventable chronic infectious disease among young children and adolescents in the United States. Dental caries impact children five times more than asthma. Nationally in 2015-2016, 45.8 percent of youth ages 2-19 experienced dental caries (untreated and treated decay) in their primary or permanent teeth. Among children ages 6-11, approximately 50.5 percent experienced dental caries and 15.3 percent suffered from untreated decay. Rates for Black and Hispanic children being higher than for white and Asian children. If dental decay remains untreated, it can cause pain and infection leading to problems with chewing, swallowing, speaking, and learning. These problems jeopardize children's physical growth, self-esteem, and capacity to socialize.

Poor oral health is also associated with missing school and poor school performance. Research estimated that U.S. children missmore than 51 million school hours annually due to dental problems. Children with poor oral health are three times more likelyto miss school and four times more likely to perform poorly when compared to their healthy counterparts. Additionally, parents miss on average 2.5 days from work per year due to their children's dental problems.

A cost-effective way of preventing tooth decay are dental sealants. Dental sealants are thin protective coatings that adhere to

the chewing surfaces of the back teeth (molars) and prevent the acid of leftover food particles from creating holes, or cavities, in the teeth. Dental sealants can prevent up to 80 percent of cavities and protect teeth for several years. While children with dental sealants have increased over time, low income children are 20 percent less likely to have them and are twice more likely to have untreated decay than high-income children. The objective is to reduce children receiving dental health service to 50.9 percent by 2026. Barriers from receiving dental sealants or other dental care include the lack of access to dental services, dental care costs, and inadequate oral health literacy.

Oral health data is needed for ongoing surveillance, establishing the burden of oral health disease, and informing statewide programmatic planning efforts. To address the need for state level oral health surveillance data, the FDOH's Public Health Dental Program (PHDP) has established a surveillance system for monitoring oral health status, risk factors, and access to dental services among various populations. The PHDP has completed surveillance projects on third grade children (2013-2014 and 2016-2017), Early Head Start and Head Start children (2014-2015 and 2017-2018), and older adults in congregate meal sites (2015-2016). In addition, PHDP worked with the Florida Dental Hygienists' Association to evaluate previous surveillance projects among children using Title V to enhance the upcoming 2021-2022 Third Grade Project and 2022-2023 Adolescent Project.

Title V supported the continued development and enhancement of the Public Health Dental Program's Florida's Linked Oral Status System (FLOSS) Database which includes the School-Based Sealant Program Module and the Oral Health Surveillance Module. The School-Based Sealant Program Module is used by all agencies and programs providing services at schools in Florida to enter aggregate data and information regarding their local School-Based Sealant Programs on a yearly basis. The PHDP has collected data on the number of children served, schools visited, services provided, and other programmatic information during the 2016-2017, 2017-2018, 2018-2019, and 2019-2020 school years. The system is accessible by both the FDOH internal and non-FDOH external partners and serves as the true statewide data warehouse for important public health dental measures for children. The Oral Health Surveillance Module is used to collect and validate data using the Basic Screening Survey Methodology developed by the Association of State and Territorial Dental Directors, for populations such as preschool and school age children. The 2017-2018 Head Start Oral Health Screening Project used this new module for the first time to collect oral health indicators and consent form questions entered by dental hygienist screeners in the field and then validated against paper records by PHDP staff. The PHDP will use the Oral Health Surveillance Module for the upcoming third grade and adolescent screening projects. Using the FLOSS database for this data collection and validation has reduced data entry errors and improved overall data quality. During SFY 2020-2021, Title V funding has continued to support the development of the FLOSS database to improve functionality, enhance data quality and accuracy, and meet the dynamic business needs of the PHDP and FLOSS users.

Objective: By September 30, 2022, increase the number of school-based sealant programs (internal or external) completing annual reports in FLOSS from 51 programs (SFY 2019-2020) to 57 programs.

The FDOH's Public Health Dental Program analyzed the 2017-2018 Head Start surveillance data and disseminated a report with the full results to our partners and the public.

Key Findings:

- Nearly one in four Head Start children aged 3-6 years (24.0%) had untreated decay.
- Non-Hispanic Black children (28.3%) had the highest prevalence of untreated decay.
- Approximately one third of Head Start children (34.3%) had dental caries (treated or untreated decay).
- Children aged 5-6 years (41.9%) had the highest rate of dental caries experience.
- One in five of Head Start children (20.8%) had an early dental treatment need.
- Uninsured children had a higher prevalence of untreated decay and a lower prevalence of treated decay than insured children (28.5% and 13.4% respectively).

Florida's overall Head Start population estimates are above the Healthy People 2020 goals related to the prevalence of untreated decay and dental caries among children ages 3-5 years (Table 1). The oral health screenings did not capture dental sealants among Florida's Head Start children because they do not have molars to be sealed.

Table 1. Oral Health Status of Florida's Head Start Population compared to National Healthy People 2020 Goals		
Oral Health Indicator	Florida's Status 2017-2018	National Target for Children Age 3-5 Based on Healthy People 2020 Goals
Dental Caries Experience	34.3%	30.0%
Untreated Dental Decay	24.0%	21.4%
Dental Sealants	---	1.5%

The FDOH works to make continued progress to improve access to preventive dental care for children in Florida. Title V funding has been provided to county health departments through Schedule C to initiate and expand the provision of preventive services for children in Early Head Start, Head Start, Women Infant and Children (WIC), Early Learning Centers, and schools throughout Florida. Continued collaborative partnerships with School-Based Sealant programs to share information on evidence-based prevention and early intervention practices facilitates the promotion of oral disease prevention efforts starting in young children.

To increase the percentage of parents who read to their young children, Title V funding was provided to county health departments through Schedule C and a statement of work, with an option to create a reading rich environment in waiting room areas such as a child's reading table and chairs, a bookshelf, children's books, etc. Funds were also available to establish a Reach Out and Read (ROR) program. ROR is an evidence-based early intervention model that encourages literacy and school readiness. ROR gives young children a foundation for success by incorporating books into pediatric care and encourages families to read aloud together. ROR medical providers encourage families to read aloud and engage with their infants, toddlers, and preschoolers every day. Additionally, medical providers give books to children at more than 10 well-child visits from infancy until they start school.

Literacy is a known factor impacting the social determinants of health. Healthy People 2020 includes school readiness and literacy in the early and middle childhood domains and objectives. In 2020, 27.4 percent of parents read to their young children. The FDOH aims to increase the percentage of parents who read to their your children to 38.7 percent by 2026.

As recommended by the American Academy of Pediatrics, ROR incorporates early literacy into pediatric practice, equipping parents with tools and knowledge to ensure that their children are prepared to learn when they start school. Through this evidence-based intervention, parents learn new ways to stimulate their children's literacy development, have more books in their home, and read to their children more. Parents are supported as their children's first and most important teachers, and children are given a foundation for success.

Child Health - Application Year

The School Health Services Program will continue to fulfill statutory, regulatory, and FDOH mandates to ensure the provision of school health services to children in all of Florida's public and participating nonpublic schools. County health departments, in cooperation with local education agencies and other partners, will work to ensure Florida's 2.8 million pre-kindergarten through 12th grade students have access to health services that assess, protect, and promote their health andability to learn.

School health services provided in all public schools include: nursing assessments; student health record reviews to ensure physical exam and immunization requirements meet statutory requirements; health services for chronic or complex health conditions requiring school-day management; first aid; medication administration; screening, referral and follow-up for vision, hearing, scoliosis and growth and development; preventive oral health programs; healthy lifestyle nursing interventions; emergency health services; health education classes; parent and staff consultations on student health issues; case management; and consultation for placement of students in exceptional student education programs. In addition, schools designated as Comprehensive or Full-Service schools by local programs receive additional services which addressmany social determinants of students' health which impact educational achievement. County School Health Programs led by registered school nurses address health disparities and work to meet student and family needs every day (NASN, 2016).

The School Health Services program was awarded a one-million-dollar grant for the 2020-2021 school year under the Substance Abuse and Mental Health Services Administration (SAMHSA) to implement evidence trauma based mental health training in schools affected by Hurricane Michael including the counties: Jackson, Calhoun, Liberty, Bay, Gulf and Gadsden. The School Health Services Program in collaboration with the National Center for School Mental Health at the College of Medicine of theUniversity of Maryland provides evidence-based curriculum. The effectiveness of the training will be evaluated by theSHAPE system, a program developed by the National Center for School Mental Health to determine the effectiveness of mental health services in schools. SAMHSA has asked that Florida lead the regional monthly technical assistance calls and has asked the School Health Services program to extend their services to other counties, which they have already started by including Escambia County.

The FDOH's School Health Services Program will continue to develop collaborative partnerships with the Florida Department of Education (DOE) Office of Healthy Schools, DOE Office of Safe Schools, Bureau of Exceptional Education and Student Services (BEESS), Florida Partnership for Healthy Schools. These partnerships promote implementation of the CDC's Whole School, Whole Community, Whole Child (WSCC) model in Florida's school districts and provide professional development for registered school nurses. The WSCC model is an evidence-based approach to advance the development of state, district, and school infrastructures which promote and maintain health and wellness for students, families, communities and school staff, and support student academic achievement. The School Health Advisory Committee (SHAC), a statutory requirement for each county School Health Program, is an important vehicle for counties todevelop their WSCC models. However, gaining and maintaining SHAC representation from all 10 components of the WSCC model is an ongoing challenge for most county School Health Programs. The School Health Program will continue to address this need offering SHAC related updates and SHAC development content during its 2021-22 monthly conference calls. Also, SHAC development will continue to be a primary focus of school health liaisons during on-site program monitoring meetings with county School Health Program staff.

The School Health Services Program will continue to work with DOE to advance the Partnership's Florida Healthy School District self- assessment and recognition program. In addition, the School Health Program will educate county school health programson the requirements, application process and benefits of becoming a Florida Healthy District on at least one programmaticstatewide conference call and during county School Health Services Program on-site program monitoring meetings duringthe 2021-22– school year. The School Health Services program will also partner with the Department of Education in developing a new Florida Healthy Schools website. These activities will support Objective 3 to increase the number of Florida school districts that apply for recognition as a Florida Healthy District for the 2021-22-application period.

The Florida Healthy School District Self-Assessment Tool was developed by experts from state agencies, school districts and community partners to assist school districts achieve the highest standards related to the CDC's Coordinated School Health and WSCC models, based on district infrastructure, policy, programs, and practices identified from national and state guidelines, best practices and Florida Statutes. This planning tool helps school districts assess and determine current status and what they could do to remove health-related barriers to learning as they work towards recognition as a Florida Healthy District. Districts are encouraged to include school superintendents, school boards, school administrators, school nurses, component area experts, parents, and the SHAC in the assessment process.

The School Health Services Program will promote school nurses' use of the Healthy Lifestyle Intervention by educating county School Health Programs about the Healthy Lifestyle Individualized Healthcare Plan and coding this service in the FDOH's data system. This training will be provided on at least one programmatic statewide conference call and will be a focus of liaisons' on-site program monitoring meetings with county School Health Program staff during the 2019–20 school year. These activities will support Objectives 1 and 2.

Challenges:

- Florida's registered school nurse to student ratio is 1 to 2,476 (2019-2020); whereas the National Association of School Nurses (NASN), American Academy of Pediatrics and American Academy of Nursing recommend one professional registered school nurse for every school, all day, every day. Inadequate registered nursing staff limits the ability to organize and conduct health education classes, wellness promotion activities and additional registered nursing services such as Healthy Lifestyle Interventions.
- There are an estimated 331,182 children or 7.6 percent of Florida's children under the age of 19 uninsured according to the United States Census Bureau Small Area Health Insurance Estimates (2018). For many students, the registered school nurse is the only licensed healthcare professional to which they have access, including for clinical guidance and support to practice a healthy lifestyle.
- The shift in community primary care services from county health departments to other healthcare providers, such as federally qualified health centers, presents challenges to ensuring students in need of follow-up care receive necessary services.
- School district prioritization of academic and standardized testing schedules presents ongoing challenges to including student health promotion activities during the school day, such as health education and additional initiatives to increase student physical activity.
- The School Health Services Program was limited to being able to educate and monitor counties due to the COVID-19 pandemic.

Title V funding has been consistently used to establish new School-Based Sealant Programs (S-BSPs) in Florida as well as expand existing sustainable programs to serve more children. These evidence-based programs increase access and reduce barriers to preventive dental care for low-income children in Title I schools, Early Head Start (EHS), Head Start (HS), Early Learning Coalition (ELC) centers, and Women Infant and Child (WIC) sites. During SFY 2019-2020, the FDOH used Title V to provide funding for the expansion of twelve S-BSPs in counties with high unmet needs due a lack of dental providers, transportation barriers and low social economic factors influencing access to care. These expansion programs were Bay, Calhoun/Liberty, Charlotte, Clay, Hendry/Glades, Highlands, Jackson, Nassau, Orange, Polk, Wakulla and Walton. These S-BSPs provided preventive services to children in EHS, HS, WIC and ELC children. Final data reveal the twelve counties funded by Title V provided services to 9,606 children including 9,734 screenings/assessments, 10,861 dental sealants, 10,084 fluoride varnish applications, and 9,689 oral health instructions during SFY 2019-2020. For SFY 2020-2021, Title V funded eight counties to expand their programs to reach additional schools and children. These counties were Baker, Broward, Columbia, Leon, Okeechobee, Palm Beach, Pinellas and Putnam. Title V funding will continue to fund the expansion of existing programs for SFY 2021-2022. It is anticipated that ten existing programs will receive funding during SFY 2020-2021.

To promote S-BSPs to children and increase positive consent rates from parents, the PHDP produced and disseminated a postcard explaining dental sealants and their effectiveness in preventing tooth decay to each of the new programs, utilizing Title V funding. The postcards incorporate best practices for health literacy and implementation of healthy oral health behaviors in second and third grade children, the target population of the S-BSPs. The postcard encourages discussion of improved oral hygiene, specifically the benefits of dental sealants, between teachers, children and their parents or guardians. Along with the postcard, the PHDP purchased educational workbooks which align with statewide tests. These workbooks provide education on maintaining good oral health and encourage the discussion with parents on promoting oral hygiene in the home. The PHDP will continue to provide Florida S-BSPs with quality improvement and assurance guidance, technical assistance and training to ensure local program efficiencies and increased capacity of children served through these programs.

The MCH Section has also partnered with the Violence and Injury Prevention Section and Children's Medical Services to develop and implement a statewide comprehensive drowning prevention campaign. Various media assets have been developed and will be distributed in the coming year.

The PHDP will continue to partner with other state agencies and not-for-profit organizations, such as Oral Health Florida,

to plan and implement programs to benefit the oral health needs of children and families. The PHDP actively participates on various Oral Health Florida action teams (committees) and the leadership council to support initiatives to increase oral health services for children and families in Florida. In 2018 the PHDP received the Centers for Disease Control and Prevention's (CDC) State Actions to Improve Oral Health Outcomes 5-year grant in support of oral health promotion and disease control. As part of the grant, the PHDP partnered with Oral Health Florida's School Health Action Team to establish a Sealant Work Group for improving the sustainability of S-BSPs. The Sealant Work Group will address the quality of S-BSP services by facilitating meetings and conducting regional trainings to assist S-BSPs with improving their sustainability and increasing the number of children served and preventive services provided. The PHDP will also use the CDC Grant to potentially provide additional funding to seven S-BSPs to expand their reach and improve their programs. Working with county health department dental programs, federally qualified health centers, and local oral health coalitions across the state, preventive services will continue to be provided to low income children in Title I Schools, EHS, HS, ELC, and WIC sites. Providing services to children in school settings eliminates many barriers that impact access to dental care. S-BSPs are supported and enhanced by Title V funding and make it possible to reach high-risk children in need of dental services and improve dental outcomes for children in the state.

During the coming year, the PHDP will continue to increase statewide data capacity and serve as the state's S-BSP data warehouse across all agencies through the FLOSS Database. Participation in the FLOSS database, especially for outside entities, will be encouraged through the Sealant Work Group of Oral Health Florida's School Health Action Team. In addition, the PHDP will be obtaining consent from schools to participate in the 2021-2022 Third Grade Oral Screening Project, which will collect data using FLOSS.

To increase the percentage of parents who read to their young children, Title V funding will continue to be available to county health departments through Schedule C and a statement of work with an option to create a reading rich environment in waiting room areas such as a child's reading table and chairs, a bookshelf, children's books, etc. Funds may also be used to establish a Reach Out and Read (ROR) program.

In April 2018, Florida Children's Council released a statewide report that finds current policies adversely impact Florida's low-income families. With more than four million children and youth calling Florida home, and 45 percent of them living in economically struggling households, it is clear that many programs designed to help families become financially stable and self-sufficient fail to work. If children from low-income homes are to reach their full potential, there is a significant need toeliminate the current silos addressing adult-oriented and child-oriented programs separately. The report provides a roadmap of action to improve economic stability and child outcomes for families with young children in poverty.

Positive child and youth outcomes, financial stability for families, and economic vitality for businesses are interrelated goals. There is a clear need to rethink social service policy and align work-based solutions with child and family supports. These two-generational strategies provide a framework for developing systems that support strong child and youth outcomes within the context of family.

In Florida, many low-income households have working parents but they remain poor despite their efforts to progress toward economic prosperity. While accessing social services can provide needed financial supports for households, in many instances income eligibility requirements force parents to choose between wage increases and critical needs of children, such as child care. This reality has significant implications not only for the children and family, but also for employers and the economy.

Assisting parents to connect with opportunities to increase economic stability, increases their power to improve the likelihood of future success for their children. There are systemic barriers that hinder a family's ability to become economically self-sufficient and by strategically aligning systems of care, there is the opportunity to ensure that all children live in stable and nurturing environments.

Families with young children in poverty have different household survival budgets needs than individuals in poverty. Reforming social services for families with young children is timely and necessary. Aligning social services such as workforce development and child care can create the opportunity for a pathway to prosperity.

Florida is a vibrant and growing state that has its share of opportunities and challenges. To ensure that we secure paths to prosperity for all Floridians, especially the nearly one million kids living in poverty, we must focus on bold and broad strategies that consider two-generation approaches.

Another part of the solution is the FDOH's continued support of the Florida's Healthy Babies Initiative where Title V funding

is allocated for county health departments to select one or more of the following projects to implement in their respective communities and previously discussed under the D.2 Budget:

- Title V funding will continue to be available to county health departments to establish a Reach Out and Read (ROR) program and/or create a reading rich environment in waiting room areas such as a child's reading table and chairs, a bookshelf, and children's books.
- Implement the Protocol for Assessing Community Excellence in Environmental Health (PACE EH) in communities of high need to assess neighborhood and community identified social determinants of health needs and provide action plans to address the top issues as defined by the communities.

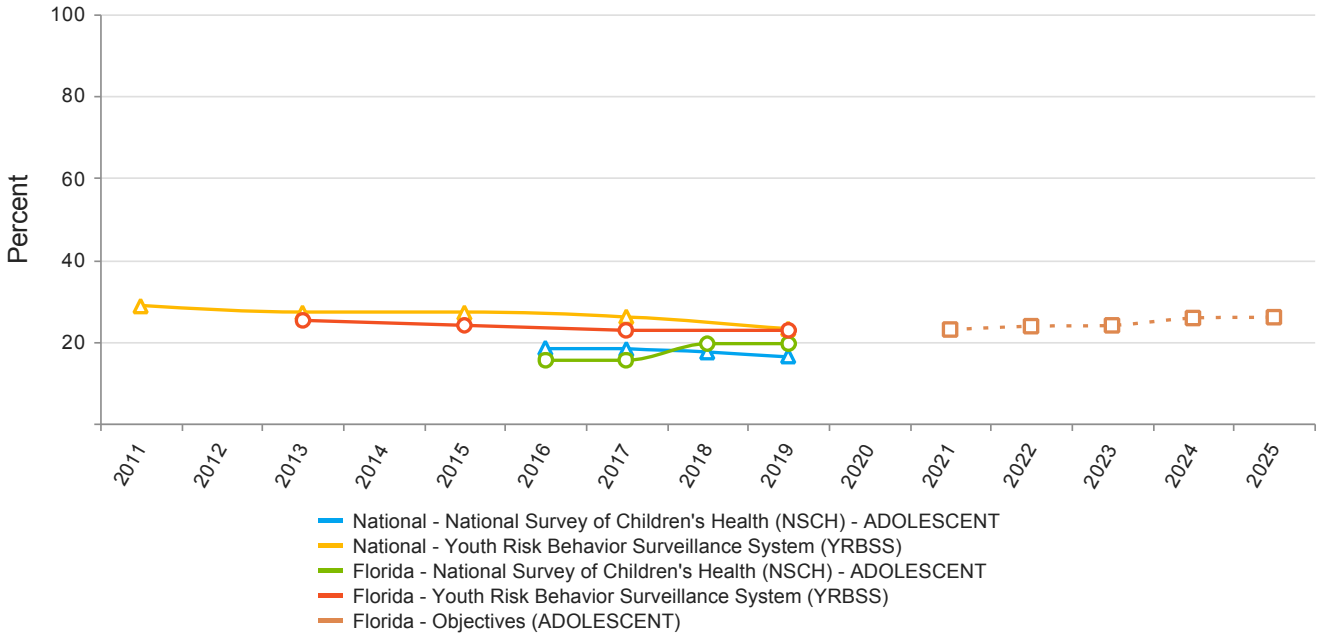
Adolescent Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS-2019	31.6	NPM 9
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2017_2019	9.2	NPM 9
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	91.3 %	NPM 8.2
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	NSCH-2018_2019	17.8 %	NPM 8.2
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	WIC-2018	13.3 %	NPM 8.2
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	YRBSS-2019	14.0 %	NPM 8.2

National Performance Measures

NPM 8.2 - Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day
Indicators and Annual Objectives



Federally Available Data		
Data Source: Youth Risk Behavior Surveillance System (YRBSS)		
	2019	**2020**
Annual Objective		
Annual Indicator	22.8	22.7
Numerator	181,534	185,277
Denominator	796,158	816,019
Data Source	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT
Data Source Year	2017	2019

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - ADOLESCENT		
	2019	**2020**
Annual Objective		
Annual Indicator	19.5	19.5
Numerator	290,239	280,894
Denominator	1,491,681	1,441,461
Data Source	NSCH-ADOLESCENT	NSCH-ADOLESCENT
Data Source Year	2017_2018	2018_2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	23.0	23.8	24.0	25.8	26.0	26.9

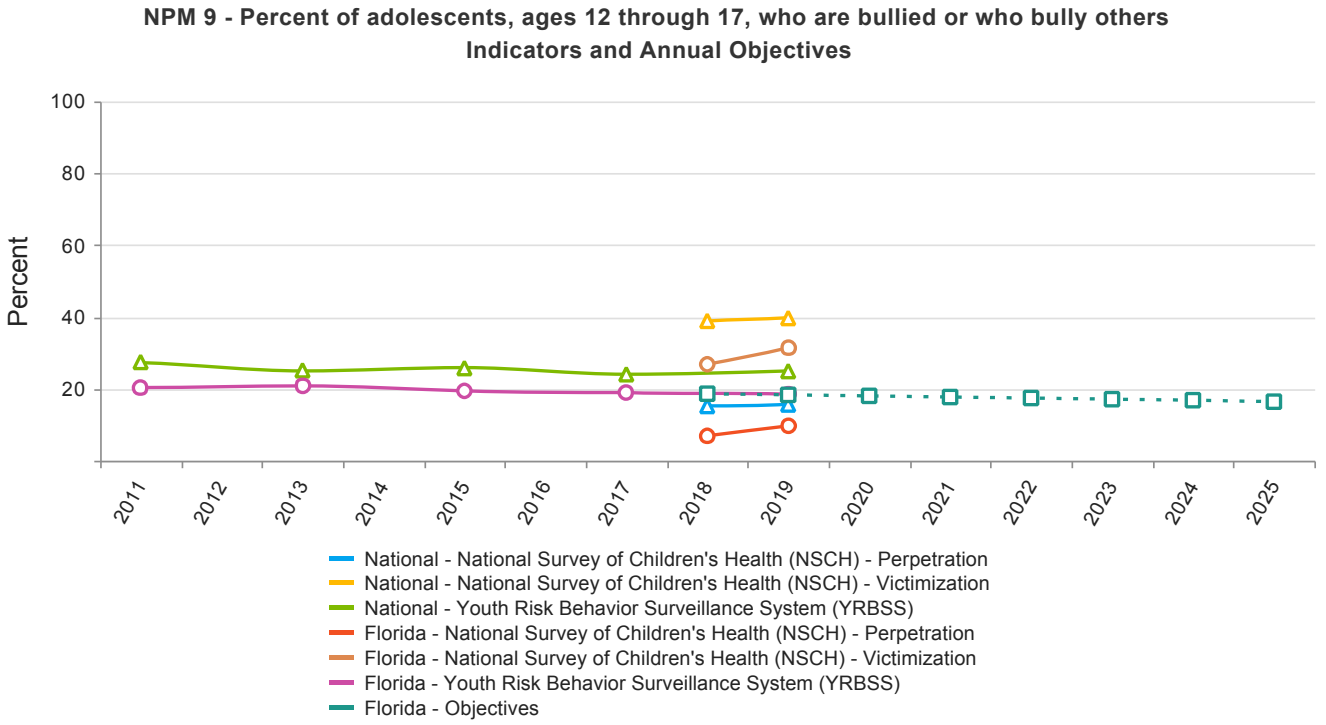
Evidence-Based or –Informed Strategy Measures

ESM 8.2.1 - The cumulative total of Florida school districts that have ever been awarded the evidence-based Florida Healthy School District recognition.

Measure Status:	Active

State Provided Data	
	2020
Annual Objective	
Annual Indicator	49
Numerator	
Denominator	
Data Source	Safe and Healthy Schools Florida
Data Source Year	2020
Provisional or Final ?	Final

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	56.0	57.0	58.0	59.0	61.0



Federally Available Data					
Data Source: Youth Risk Behavior Surveillance System (YRBSS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	20.2	19	18.7	18.4	18.1
Annual Indicator	19.5	19.5	18.9	18.9	18.8
Numerator	150,914	150,914	156,700	156,700	159,632
Denominator	772,407	772,407	827,044	827,044	847,255
Data Source	YRBSS	YRBSS	YRBSS	YRBSS	YRBSS
Data Source Year	2015	2015	2017	2017	2019

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - Perpetration				
	2017	**2018**	**2019**	**2020**
Annual Objective			18.4	18.1
Annual Indicator			6.9	9.7
Numerator			98,203	140,699
Denominator			1,426,809	1,444,881
Data Source			NSCHP	NSCHP
Data Source Year			2018	2018_2019

Previous NPM-9 NSCH data for survey years 2016 and 2017 that was pre-populated under the 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable to 2018 survey data given major wording and response option changes.

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - Victimization				
	2017	**2018**	**2019**	**2020**
Annual Objective			18.4	18.1
Annual Indicator			26.8	31.3
Numerator			383,474	452,299
Denominator			1,429,420	1,446,186
Data Source			NSCHV	NSCHV
Data Source Year			2018	2018_2019

Previous NPM-9 NSCH data for survey years 2016 and 2017 that was pre-populated under the 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable to 2018 survey data given major wording and response option changes.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	17.8	17.5	17.2	16.9	16.5	16.2

Evidence-Based or –Informed Strategy Measures

ESM 9.1 - The number of students who participate in an evidence-based program that promotes positive youth development and non-violence intervention skills

Measure Status:			Active	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			13,100	13,500
Annual Indicator			12,625	13,205
Numerator				
Denominator				
Data Source			FDOH - Adolescent Health Program	FDOH - Adolescent Health Program
Data Source Year			2019	2020
Provisional or Final ?			Final	Final

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	13,900.0	14,300.0	14,700.0	15,100.0	15,500.0	15,900.0

State Action Plan Table

State Action Plan Table (Florida) - Adolescent Health - Entry 1	
Priority Need	
Promote activities to improve the health of children and adolescents and promote participation in extracurricular and/or out-of- school activities in a safe and healthy environment.	
NPM	
NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others	
Objectives	
1. By 2026, decrease the number of Florida high school students who experienced bullying on school property from 14.3 percent (2017: BRFSS) to 16.2 percent.	
2. By 2026, decrease the number of Florida high school students who experienced electronic bullying in the past 12 months from 11.5 percent (2017: BRFSS) to 10 percent.	
3. By 2026, increase the number of youth participating in positive youth development programs from 12,300 (2017) to 15,900.	
Strategies	
1a. Partner with community agencies and organizations to promote bullying prevention initiatives.	
1b. Coordinate with the Department of Education's Safe Schools Program to integrate additional anti-bullying and violence prevention messages.	
2. Increase the number of youth with access to resources and hotlines related to violence and bullying prevention.	
3a. Promote the use of evidence-based curriculums.	
3b. Ensure that youth are receiving STD/HIV information and sexual risk avoidance strategies.	
3c. Provide positive youth development education to encourage healthy behaviors and the reduction of risky behaviors.	
ESMs	**Status**
ESM 9.1 - The number of students who participate in an evidence-based program that promotes positive youth development and non-violence intervention skills	Active
NOMs	
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	

State Action Plan Table (Florida) - Adolescent Health - Entry 2

Priority Need

Promote activities to improve the health of children and adolescents and promote participation in extracurricular and/or out-of- school activities in a safe and healthy environment.

NPM

NPM 8.2 - Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day

Objectives

1. By 2026, increase the percent of adolescents (ages 12-17) who are physically active at least 60 minutes per day from 19.5 (2020: NSCH) to 26.9.

2. By June 30, 2022, increase the percentage of successful referrals for growth and development screening with body mass index (BMI) results at or above the 95th percentile resulting in students receiving services from a health care provider from 32.25 percent (2017-18 baseline) to 37.50 percent. This measure is the sum of completed referrals to healthcare providers and completed Healthy Lifestyle interventions by registered school nurses.

Strategies

1. Educate county school health programs about the use of the Healthy Lifestyle Intervention Individualized Healthcare Plan and coding this service data in the Department’s Health Management System.

2. Educate county school health programs on the requirements, application process, and benefits of becoming a Florida Healthy District.

3. Continue School Health Services Program involvement in the Florida Partnership for Healthy Schools, the Healthy District Collaborative, and the Interagency Collaborative.

4. Promote the Center for Disease Control and Prevention’s Whole School, Whole Community, Whole Child approach by educating county school health programs on strategies to expand school health advisory committee representation, including student/parent involvement.

5. Promote policy, systems, and environmental approaches to increasing physical activity opportunities within the built environment for Floridians of all ages through coordination with local governments and stakeholders such as the Florida Department of Transportation, the Florida Recreation and Parks Association, East Central Florida Regional Planning Council, the Florida Department of Agriculture and Consumer Services, the Florida Department of Education and Florida Action for Healthy Kids.

ESMs	Status
ESM 8.2.1 - The cumulative total of Florida school districts that have ever been awarded the evidence-basedFlorida Healthy School District recognition.	Active

NOMs

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

Adolescent Health - Annual Report

The Adolescent Health Program (AHP) strives to empower and educate youth to make healthy choices and improve the health ofadolescents and young adults by decreasing the percentage of youth engaging in risky behaviors that lead to teen pregnancy, sexually transmitted infections, substance use, and violence. The AHP continues to implement the Sexual Risk Avoidance Education (SRAE) Program, which began in 2010.

The SRAE Program funded 12 providers, seven local health departments, and five community or faith-based providers in middleschool, high school, and community settings. In the 2019-2020 grant year (most recently available), the Sexual Risk Avoidance Program was successfully delivered to 12,930 youth and to 2,810 parents and guardians.

The Title V State Sexual Risk Avoidance Education Grant, from the Administration of Children and Families, funded local health departments and community and faith-based organizations to implement evidence-based sexual risk avoidance education curricula including *Choosing the Best*, *Making A Difference*, *Promoting Health Among Teens*, and *Real Essentials*. The curricula encourage parent and guardian involvement. The parent programs reinforce healthy behaviors, encourage positive attitudes, and reduce risk-taking behaviors. All classes were delivered in school or community-based settings. Monitoring of providers was carried out to evaluate and ensure fidelity to the curriculum. The monitoring, conducted by program contract managers, included observation of the instructor providing education classes to assess adherence to the curriculum.

While there were no major changes to the state plan, the impact of COVID-19 on communities delayed scheduling and implementation. This resulted in providers navigating adaptations to in-person implementation with community and school leaders while working to maintain safety for youth, parents, and program staff. Additionally, educators adapted programming for virtual learning using innovative strategies to offer engaging web-based classes. This adaptability allowed the AHP to meet, and in some areas, exceed the target number of youth served for the year.

Being aware that adolescents needed specialized support during this year, AHP staff worked in partnership with other youth-serving programs to develop the Youth COVID-19 toolkit. It was designed to engage, educate and empower young people, ages 12-24, around stopping the spread of COVID-19. The toolkit includes FAQ's, best practices, and social media resources that may be used by youth-serving partners.

Section 1006.147, Florida Statutes, requires Florida school districts to adopt a policy prohibiting bullying and harassment of students and staff on school grounds or school transportation, at school-sponsored events, and through the use of data or computer software accessed through school computer systems or networks. The Department of Education Office of Safe Schools has created a model policy against bullying and harassment that school districts can use to craft their individual policies.

Bullying is a serious detriment to a child's health, sense of well-being, safety, education, and emotional development, and greatly increases the risk of self-injury and suicide. According to the 2019 (the most current year) CDC Youth Risk Behavioral Survey (YRBS), 14.9 percent of Florida high school students were bullied on school property and 11.3 percent were bullied electronically. Bullying is defined as an attack or intimidation with the intention to cause fear, distress, or harm that is either physical (hitting, punching), verbal (name calling, teasing), or psychological/relational (rumors, social exclusion); a real or perceived imbalance of power between the bully and the victim; and repeated attacks or intimidation between the same children over time. Data from the 2019 YRBS indicate that a significantly higher number of students experiencing bullying described their grades as Ds and Fs in school during the past 12 months. The number of ninth and 10th grade students reporting being bullied is significantly higher than for students in 11th and 12th grade. Female students are significantly more likely than males to have experienced some form of bullying, name calling, or teasing in the past year.

Adolescents who report frequently bullying others and youth who report being frequently bullied are at increased risk for suicide-related behavior. According to the National Vital Statistics System, adolescent suicide rates for ages 15-19 increased slightly from 9.0 deaths per 100,000 for 2016-2018 to 9.2 deaths per 100,000 for 2017-2019. Adolescent mortality also increased slightly from 30.7 per 100,000 deaths in 2018 to 31.6 deaths per 100,000 in 2019.

Prior to the COVID-19 pandemic, our Title V MCH Director had the opportunity to travel around the state on behalf of Florida's First Lady to participate in a mental health listening tour. This tour convened state leaders from FDOH and DOE with local leaders including school and district level staff and students from the district. Students were given an opportunity to share what their experiences were like. This listening tour provided information that has been used to drive programs and decision making at the state level.

Adolescent Health - Application Year

The Adolescent Health Program (AHP) works to promote, protect, and improve the health of all Florida youth. As a means of working toward health equity, the AHP ensures inclusion of sexual minority populations including youth in the LGBT community. All providers funded by the AHP participate in annual, mandatory training that builds upon inclusivity. Training includes:

- Value-neutrality best practices.
- Facilitation skills that create a safe pace.
- Mandatory reporting guidelines.
- State-specific sexually transmitted disease updates.
- Anti-bullying resources, education, and promotional materials.
- Curriculum adaptation that includes gender neutral or LGBT-specific couple references (as permitted by each school district).
- Linkages to services that serve and support LGBT youth.

The AHP continues to work to increase the percentage of youth making positive and healthy choices, with the intention of improving the health of adolescents and young adults by decreasing the percentage of youth engaging in risky behaviors that lead to teen pregnancy, sexually transmitted infections, substance abuse, and violence.

The AHP also continues to implement the Sexual Risk Avoidance Grant from the Administration of Children and Families that began in 2010. This program provides $3,800,000 per year to fund county health departments and community-based organizations. The funded providers use evidence-based, proven-effective sexual risk avoidance education curricula including *Choosing the Best*, *Making A Difference*, and *Real Essentials* to deliver the program. All classes are delivered in school or community-based settings. Providers are monitored regularly to ensure fidelity to the curricula and adherence to grant guidelines. The monitoring, conducted by program contract managers, includes observation of the educator conducting classes with youth and or parents/significant adults.

The AHP is currently funding 12 providers through September 2021. These providers include seven local health departments and five community-based providers in middle school, high school, and community settings.

Students who are perceived as different by other students are more likely to be bullied. These more vulnerable students include LGBT youth; students with physical, learning, or mental health disabilities; and students who are targeted for differences in race, ethnicity, or religion. Both students who bully and students who are bullied can suffer lasting psychological effects, including post-traumatic stress disorder (PTSD).

The best deterrent to bullying and cyberbullying is to create a culture of acceptance and communication. Such a culture empowers students to find positive ways to resolve conflicts and includes administration, teachers, and other staff who can support students in making constructive decisions and respond proactively when aggression of any kind exists on the school campus.

The FDOHs Violence and Injury Prevention Section (VIP) addresses statewide injury (both intentional and unintentional) prevention through implementation of evidence-based strategies, technical assistance, information, and resources. One such program is the evidence-based *Green Dot* strategy. *Green Dot* is a bystander intervention that capitalizes on the power of peer and cultural influence across all levels of the socioecological model. *Green Dot* emphasizes that individual choices to take personal responsibility for a safe community leads to cultural norms shifts of nonviolence. In the 2019-2020 grant year, Green Dot was successfully delivered to 1,457 high school students.

Three providers implement this strategy on nine Florida high school campuses. Additionally, two providers implement in the communities of Palm Beach and Punta Gorda. Five universities implement on college campuses.

Green Dot supports the theory that a cultural shift is necessary to measurably reduce the perpetration of power-based personal violence. To create that shift, a critical mass of peer influencers must engage in a new behavior to make violence less sustainable within any given community. The new behavior includes identification of personal connection to violence, barriers to intervention, workaround solutions for barriers, and opportunities to identify risk factors for power-

based personal violence before it occurs. Prevention in the form of behavior modeling through social media and peer to peer conversations is also a component of *Green Dot*. The high school implementation intervention focuses on teen dating violence, bullying, sexual harassment, stalking, and sexual assault.

It is also important to look at the effects of trauma on children and young adults as it is far more pervasive than adults imagine. The National Survey of Children's Exposure to Violence found that over 60 percent of children surveyed experienced some form of trauma, crime, or abuse in the prior year, with some experiencing multiple traumas. Often, children and adolescents do not have the necessary coping skills to manage the impact of stressful or traumatic events. As such, as many as one in three students who experience a traumatic event might exhibit symptoms of PTSD. Following a child's exposure to a traumatic event, parents and teachers are likely to observe the following symptoms:

- Reexperiencing — constantly thinking about the event, replaying it over in their minds, nightmares.
- Avoidance — consciously trying to avoid engagement, trying not to think about the event.
- Negative Cognitions and Mood — blaming others or self, diminished interest in pleasurable activities, inability to remember key aspects of the event.
- Arousal — being on edge, being on the lookout, constantly being worried.

Symptoms resulting from trauma can directly impact a student’s ability to learn. Students might be distracted by intrusive thoughts about the event that prevents them from paying attention in class, studying, or doing well on a test. Exposure to violence can lead to decreased IQ and reading ability. Some students might avoid going to school altogether.

Exposure to violence and other traumatic events can disrupt a youths’ ability to relate to others and to successfully manage emotions. In the classroom setting, this can lead to poor behavior, which can result in reduced instructional time, suspensions, and expulsions. Long-term results of exposure to violence include lower grade point averages and reduced graduation rates, along with increased incidences of teen pregnancy, joblessness, and poverty.

The root causes of and complex factors contributing to violence are found at the individual, family, community, and societal levels. All systems and disciplines can and must play a valuable role in preventing violence, reducing harm, and mitigating the lifelong effects of violence and trauma.

VIP partners and providers will continue focusing on three important strategies for addressing violence on the community level: supporting economic opportunities for women, leadership skills for young girls, and building protective environments. These strategies range from safe zones in school libraries to online programming for young women.

Research and action in preventing violence in schools and communities includes improving the environments in which young people live and learn; implementing policies and programs that establish new norms for nonviolent behaviors; equipping young people with competencies for positive development; and providing opportunities for employment, mentoring, substance abuse treatment, and access to health and mental health services, including trauma-informed care.

The FDOH applies a public health approach to violence prevention, concentrating primarily on preventing youth violence, sexual violence, intimate partner violence, and exposure to trauma. This approach involves research, evaluation, and training and technical assistance across many of society’s systems, such as schools, law enforcement and the courts, mental health, child welfare, and juvenile justice agencies. The FDOH’s priority to address the social determinants of health is embedded throughout this application and the commitment of leadership as evidenced by the State Health Improvement Plan and Agency Strategic Plan to impact Florida’s long-term health outcomes.

Children with Special Health Care Needs

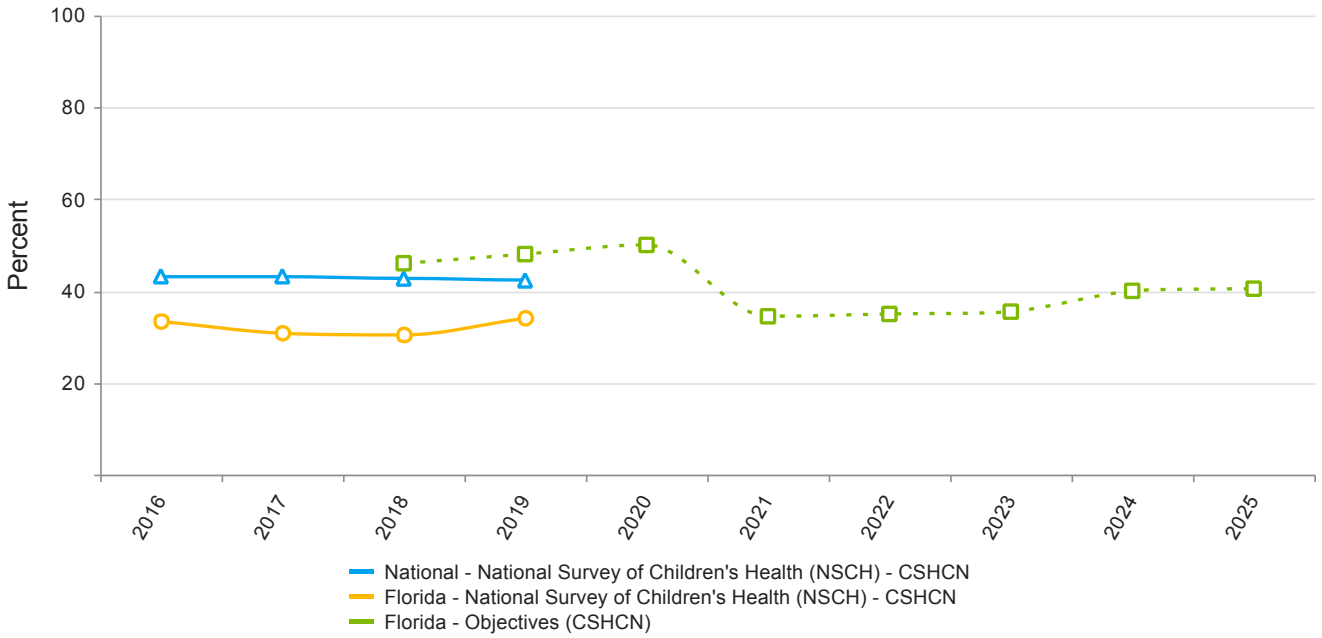
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2018_2019	7.7 %	NPM 11 NPM 12
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2018_2019	53.0 %	NPM 11
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	91.3 %	NPM 11
NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year	NSCH-2018_2019	3.6 %	NPM 11

National Performance Measures

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Indicators and Annual Objectives



NPM 11 - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			46	48	50
Annual Indicator		33.5	30.8	30.3	34.1
Numerator		298,857	264,895	238,785	263,392
Denominator		891,111	860,723	787,817	771,337
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	34.5	35.0	35.5	40.0	40.5	41.0

Evidence-Based or –Informed Strategy Measures

ESM 11.1 - Number of DOH team members, providers (pediatric, family practice, and adult), families, family partners, and other partners serving CYSHCN in Florida receiving education or technical assistance about the patient-centered medical home model and relat

Measure Status:	Active

State Provided Data	
	2020
Annual Objective	
Annual Indicator	1,847
Numerator	
Denominator	
Data Source	CMS Public Health Detailing activity log
Data Source Year	2020
Provisional or Final ?	Final

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	0.0	0.0	0.0	0.0	0.0

ESM 11.2 - Percentage of caregivers of CYSHCN in Florida who perceive themselves as a partner in their child's care.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	71.0	72.0	73.0	74.0	75.0

ESM 11.3 - Percentage of providers in underserved geographic areas that received formal technical assistance through the UCF HealthARCH program that became designated patient-centered medical homes.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	0.0	0.0	0.0	0.0	0.0

ESM 11.4 - Number of Adult Care Providers/Practices that report accepting CYSHCN transitioning to adult care.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	0.0	0.0	0.0	0.0	0.0

State Performance Measures

SPM 1 - The percentage of children that need mental health services that actually receive mental health services.

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		58	50	51	52
Annual Indicator	57.7	49.1	46.5	48.2	52.9
Numerator				99,630	225,227
Denominator				206,702	425,445
Data Source	National Survey of Children's Health	National Survey of Children's Health	National Survey of Children's Health	National Survey of Children's Health	National Survey of Children's Health
Data Source Year	2011-2012	2016	2017	2018	2018_2019
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	53.0	54.0	55.0	56.0	57.0	58.0

State Outcome Measures

SOM 1 - Percent of family satisfaction with access to care received in a patient-centered medical home and primary care for children that have special health care needs

Measure Status:	Active

State Provided Data	
	2020
Annual Objective	
Annual Indicator	72.7
Numerator	64
Denominator	88
Data Source	CYSHCN Internal Survey
Data Source Year	2021
Provisional or Final ?	Final

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	75.0	75.5	76.0	76.5	77.0

State Action Plan Table

State Action Plan Table (Florida) - Children with Special Health Care Needs - Entry 1

Priority Need

Increase access to medical homes and primary care for children with special health care needs.

NPM

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Objectives

11.1 By June 30, 2025, increase the number of DOH team members, providers (pediatric, family practice, and adult), families, family partners, and other partners serving CYSHCN in Florida who received education or technical assistance about the patient-centered medical home model and related topics that impact the health and wellness of CYSHCN from 550 annually to 1080 annually. (7/1/20-6/30/21 target: 730) (7/1/21-6/30/22 target: 810) (7/1/22-6/30/23 target: 890) (7/1/23-6/30/24 target: 980) (7/1/24-6/30/25 target: 1080)

11.2: By June 30, 2025 increase the number caregivers of CYSHCN in Florida who perceive themselves as a partner in their child's care by 5% annually from identified baseline. (7/1/20-6/30/21 target: X) (7/1/21-6/30/22 target: X+ 5%) (7/1/22-6/30/23 target: X+10%) (7/1/23-6/30/24 target: X+15%) (7/1/24-6/30/25 target: X+20%)

11.3: By June 30, 2025, increase the percentage of underserved geographic areas that have at least one pediatric practice that is designated as a PCMH by 20% (7/1/20-6/30/21 target: Xx1.03) (7/1/21-6/30/22 target: Xx1.05) (7/1/22-6/30/23 target: Xx1.1) (7/1/23-6/30/24 target: Xx1.15) (7/1/24-6/30/25 target: Xx1.2)

11.4.: By June 30, 2025 Increase the number of identified Adult Care Providers/ Practices PCMHs that will accept CYSHCN transitioning to Adult Care by 15 annually. (2021 target: baseline + 15) (2022 target: baseline + 30) (2023 target: baseline + 45) (2024 target: baseline + 60) (2025 target: baseline + 75)

Strategies

11.1: Identify, evaluate, and enhance education and technical assistance provided to DOH team members, providers (pediatric, family medicine, and adult), families, family partners, and other partners serving children and youth with special health care needs (CYSHCN) regarding the patient-centered medical home model and related topics that impact the health and wellness of CYSHCN.

11.2.1 Create a cohort of caregivers of CYSHCN that are educated and equipped to be a partner in their child's care.

11.2.2: Leverage work with existing and potential partners to increase opportunities for families of CYSHCN to become family partners at the individual, community, and systems level.

11.3.1: Create a pipeline of providers that are engaged in enhancing their practice sites based on the foundational principles of patient-centered medical homes.

11.3.2: Leverage work with existing and potential partners to increase the spread of patient-centered medical homes.

11.4: Work with other Title V CYSHCN Programs and internal Department of Health colleagues to identify and implement activities that will increase the numbers of family practice and adult providers that serve young adults with special health care needs.

ESMs	Status
ESM 11.1 - Number of DOH team members, providers (pediatric, family practice, and adult), families, family partners, and other partners serving CYSHCN in Florida receiving education or technical assistance about the patient-centered medical home model and relat	Active
ESM 11.2 - Percentage of caregivers of CYSHCN in Florida who perceive themselves as a partner in their child's care.	Active
ESM 11.3 - Percentage of providers in underserved geographic areas that received formal technical assistance through the UCF HealthARCH program that became designated patient-centered medical homes.	Active
ESM 11.4 - Number of Adult Care Providers/Practices that report accepting CYSHCN transitioning to adult care.	Active

NOMs
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health
NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year

State Action Plan Table (Florida) - Children with Special Health Care Needs - Entry 2

Priority Need

Increase access to behavioral health services

SPM

SPM 1 - The percentage of children that need mental health services that actually receive mental health services.

Objectives

1.1: By June 30, 2025, increase the number of DOH team members, providers, (pediatric, family practice, and adult), families, family partners, and community service providers in Florida who received education or technical assistance about accessing or providing access to behavioral health services from 750 annually to 1460 annually. (data source: CMS Public Health Detailing activity tracker (baseline: 750) (7/1/20-6/30/21 target: 1000) (7/1/21-6/30/22 target: 1100) (7/1/22-6/30/23 target: 1210) (7/1/23-6/30/24 target: 1330) (7/1/24-6/30/25 target: 1460)

1.2: By June 30, 2025, increase the number of traditional and non-traditional providers that have initiated integrating behavioral health services, by 3% annually from identified baseline. (data source: CMS Public Health Detailing activity tracker (baseline: X (7/1/20-6/30/21 target: X + 3% (7/1/21-6/30/22 target: X (7/1/22-6/30/23 target: X (7/1/23-6/30/24 target: X (7/1/24-6/30/25 target: X

1.3: By June 30, 2025, increase the number of activities identified that support families in enhancing mental health protective factors and build resilience by 3 annually (data source: Public Health Detailing Activity Tracker) (baseline: 0) (7/1/20-6/30/21 target: 3) (7/1/21-6/30/22 target: 6) (7/1/22-6/30/23 target: 9) (7/1/23-6/30/24 target: 12) (7/1/24-6/30/25 target: 15)

Strategies

1.1.1: Identify, evaluate, and enhance education and technical assistance provided to DOH team members, providers (pediatric, family medicine, and adult), families, family partners, and community service providers regarding accessing or providing access to behavioral health services and related topics that impact behavioral health and wellness

1.1.2. Collaborate with organizations on existing or developing Public Awareness Campaigns to increase awareness of mental health and reduce stigma

1.1.3 Leverage work with existing and potential partners to increase awareness, prevention identification, treatment activities, and treatment resources

1.2.1: Identify, develop, and disseminate resources for change management for traditional and non-traditional providers to begin behavioral health integration

1.2.2: Leverage work with existing and potential partners to increase the accessibility and utilization of needed behavioral health services

1.2.3: Create a pipeline of providers that are engaged in enhancing their practice sites by improving behavioral health awareness, prevention, identification and treatment

1.3.1: Identify, develop, and disseminate resources for traditional and non-traditional providers, as well as community partners, on available activities and resources that enhance mental health protective factors and build resilience in the families they are serving

1.3.2: Leverage work with existing and potential partners to increase activities for families that enhance mental health protective factors and build resilience

State Action Plan Table (Florida) - Children with Special Health Care Needs - Entry 3

Priority Need

Increase access to medical homes and primary care for children with special health care needs.

SOM

SOM 1 - Percent of family satisfaction with access to care received in a patient-centered medical home and primary care for children that have special health care needs

Objectives

By June 30, 2025 increase the number caregivers of CYSHCN in Florida who perceive themselves as a partner in their child's care by 5% annually from identified baseline.

Strategies

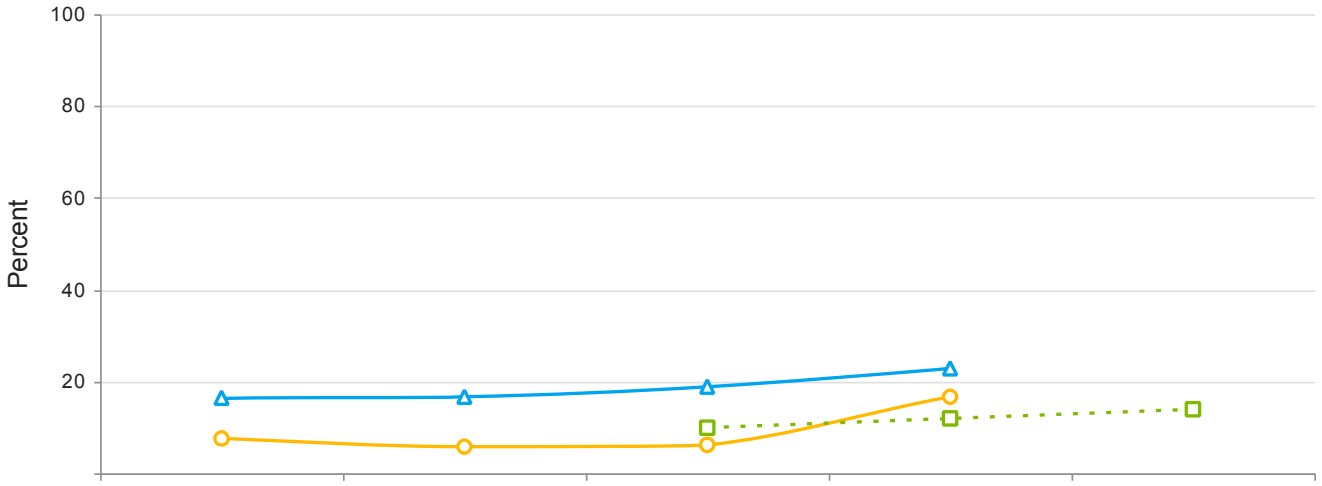
Identify, evaluate, and enhance education and technical assistance provided to DOH team members, providers (pediatric, family medicine, and adult), families, family partners, and other partners serving children and youth with special health care needs (CYSHCN) regarding the patient-centered medical home model and related topics that impact the health and wellness of CYSHCN.

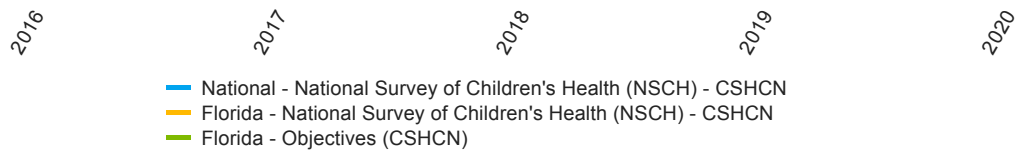
Create a cohort of caregivers of CYSHCN that are educated and equipped to be a partner in their child's care.

Leverage work with existing and potential partners to increase opportunities for families of CYSHCN to become family partners at the individual, community, and systems level.

2016-2020: National Performance Measures

2016-2020: NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care
Indicators and Annual Objectives





2016-2020: NPM 12 - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			10	12	14
Annual Indicator		7.5	5.9	6.4	16.8
Numerator		27,551	25,281	24,937	52,610
Denominator		368,685	426,713	387,391	313,204
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

2016-2020: Evidence-Based or –Informed Strategy Measures

2016-2020: ESM 12.2 - Percent of satisfaction of access for youth with special health care needs who report having access to community-based resources necessary to make transition to adult health care.

Measure Status:			**Active**	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			50	55
Annual Indicator			27.8	4.5
Numerator			5	2
Denominator			18	44
Data Source			CSHCN	CMS Internal Survey
Data Source Year			2019	2021
Provisional or Final ?			Final	Final

2016-2020: State Performance Measures

2016-2020: SPM 4 - The percentage of individuals who received workforce development that reported improved public health competency and capacity.

Measure Status:			**Active**	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			75	89
Annual Indicator			89.3	95.7
Numerator			25	22
Denominator			28	23
Data Source			CMS Internal Survey	CMS Internal Survey
Data Source Year			2020	2020
Provisional or Final ?			Final	Final

Children with Special Health Care Needs - Annual Report

Children's Medical Services (CMS) protects and promotes the health and wellbeing of Florida's children, including children and youth with special care needs through: comprehensive programs; a commitment to health equity; and a focus on social determinants of health. CMS's aim statement is for all of Florida's children to be safe, healthy , and thriving where they live, learn, and play. In Florida, 55.4% of CYSHCN have public health insurance, as compared to 37.8% Nationwide, with 40.6% reporting private insurance, 3.4% reporting a combination of public and private insurance and 0.6% uninsured. In addition, 7.7% of Florida's CYSHCN report having received care in a well-functioning system, with the reported Nationwide average of 14.1%.

To influence NOM 17.2, the percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system, CMS's framework includes five main initiatives that are woven into the findings of the annual report in no particular order. The initiatives include: 1) Transform pediatric practices into patient-centered medical homes, 2) Build capacity of pediatric primary care providers to treat common behavioral health conditions, 3) Address community integrated system building in Florida's diverse regions, 4) Improve access and quality through contracts with specialty networks that have condition-specific expertise (e.g., diabetes, sickle-cell disease), 5) Collaboratively partner with Children's Medical Services (CMS) Health Plan.

Increased access to medical homes and primary care for CYSHCN, is a continued priority need and NPM 11, along with the reported evidenced based or informed strategy measures (ESM), and performance objectives continue to align for the upcoming reporting year. ESM 11.1 is the number of FDOH team members, providers (pediatric, family practice, and adult), families, family partners, and other partners serving CYSHCN in Florida receiving education or technical assistance about the patient-centered medical home model and related topics that impact the health and wellness of CYSHCN. The objective is to increase this number annually, with 730 as the target for this year which was achieved as described below.

Supporting activities under Strategy 11.1 work to identify, evaluate, and enhance education and technical assistance provided to FDOH team members, providers (pediatric, family medicine, and adult), families, family partners, and other partners serving children and youth with special health care needs (CYSHCN) regarding the patient-centered medical home model and related topics that impact the health and wellness of CYSHCN. Activities also include an intentional focus on workforce, essential public health services and family partnerships.

To address Florida's populous state and diverse regions, CMS uses community integrated system approaches with annual regional needs assessments used to confirm or identify additional needs or gaps that impact the health and wellness of CYSHCN. The community integrated systems approach also embeds the evidence-informed practice of public health detailing. CMS utilizes 16 regional field specialists, which includes five family leaders, to provide outreach, education, technical assistance, and linkage of resources to community partners including providers that serve CYSHCN. Due to the National Pandemic, COVID-19, CMS Title V field specialists were initially diverted to public health missions aimed at mitigation and relief. They then had to learn to how to be effective without usual face to face outreach methods, instead being able to only use telephonic, email or virtual means. However, these methods proved efficient as there were 1847 encounters of outreach or education specific to PCMH topics, with 28 technical assistance events specific to completion of PCMH readiness assessments. While this accomplishment was over twice the amount of the target, it is largely in part to a dedicated campaign to recruit the needed primary care practices to participate in the upcoming PCMH transformation cohort which was more challenging than usual due to the effect of COVID-19 on primary care practices. As a result of this dedicated effort, other targets and activities were not achieved this year. Therefore, CMS will maintain the projected target for the activity in the coming year and continue to monitor activities and adjust future targets if indicated in the future years. PCMH related educational topics expanded to include COVID-19 resources, social determinates of health, Bright Futures, Universal Screening Tools, obesity and asthma. For the upcoming year, oral health for CYSHCN will also be included.

Annual regional needs assessment results identified a continued concern of increased asthma emergency department visits in many of Florida's counties. Title V CMS, as a convener, leveraged resources within the FDOH Bureau of Chronic Disease Prevention and a workgroup was started with diverse stakeholders represented including specialists and primary care providers. The group developed a one-page Asthma weblink resource guide for providers, families, and community partners. They are also building an Asthma Management in Action plan for providers, that will include a resource guide with evidenced based interventions. Asthma home visiting programs were leveraged with plans to engage volunteers for expansion. In addition, an Asthma Education Pilot program for high-risk uncontrolled Asthma patients was planned and enrollment is just beginning. School based program activities, put on hold due to COVID-19, will be considered again in the Fall.

Strategy 11.1 includes significant activities which engages several of CMS's major initiatives and focuses on community

integrated system building and improving access and quality. An informed strategy for community integrated systems approaches includes the integration of multisector service systems that work together on community needs, including addressing social determinates of health. CMS developed a framework and partnered with two existing community programs to implement its regional network for access and quality (RNAQ) pilot model. This model includes core functions of public health and the *Standards for Systems of Care for Children and Youth with Special Health Care Needs, version 2.0.,* with the goal to improve access and quality for children in their community. While in different stages of early implementation, recent efforts include moving towards collaboration with the two programs, and for the upcoming year they have a joint long term and across programs aim to decrease negative health impacts and improve the care provision to children and youth with special health care needs (CYSHCN). Specifically, the RNAQ in Jacksonville will improve PCP (primary care provider) ability to manage children and youth with special healthcare needs with behavioral and mental health conditions by providing trainings to a minimum of 12 PCPs between July 1, 2021 and June 30, 2022. The Orlando RNAQ will increase the identification of needed supports and services by increasing the use of the Nemours Children's Hospital Social Determinants of Health (SDOH) tool in the Medically Complex Coordination Clinic from a baseline of 0% in June 2021 to 50% by June 30, 2022. They will also explore nutritional services: availability, access, and reimbursement in Florida and nationally to determine opportunities within the Florida system of care for CYSHCN.

In the achievement of well-functioning system that serves CYSHCN in Florida, integrated system building work includes an intentional focus on access and quality. As another major initiative Title V, through CMS's Specialty Programs Bureau, leveraged existing specialty network contracts, in tertiary care centers across the state, that have condition-specific expertise (e.g., diabetes, sickle-cell disease). Tasks previously focused on direct care services, prior to Medicaid Managed Care, were reengineered to tasks associated with: 1) Title V CYSHCN priorities 2) The *Standards for Systems of Care for Children and Youth with Special Health Care Needs, version 2.0.* 3) Implementation of a Quality of Life measurement tool 4) Completion of the CYSHCN single organization assessment tool and 5) Quality Improvement. The vision includes uniting these individual tertiary care condition specific programs and organizations across the state, into collaborative Statewide Networks of Access and Quality (SNAQs). Guiding principles include a family-centered, learning through quality improvement (QI), kid-focused, inclusive, data-driven, systems of care that serves all CYSHCN, regardless of insurance status and location.

A significant activity (11.1.a.vi) works to engage various provider groups serving CYSHCN through a learning collaborative approach to share best practices, focus activities on strengthening the system of care for CYSHCN, and their families utilizing the Standards for Systems of Care for Children and Youth with Special Health Care Needs, version 2.0, and working together on quality improvement projects to improve the health and wellbeing of CYSHCN and their families. In promoting this culture of learning and continuous quality improvement Title V partnered with the National Institute for Children's Health Quality (NICHQ) to create a Learning Action Network (LAN) and Quality Improvement initiative with its SNAQ programs. For this second full year of implementation, LAN objectives included: 1) Build and support will for QI, 2) Facilitate continuous QI, 3) Foster collaboration and shared learning and action towards improvement, 4) Through co-design and co-facilitation, NICHQ and CMS will develop a sustainable Learning and Action Network. The LAN initiative is noted to have been a catalyst in the transformation of these historical siloed organizations, into the emergence of a Statewide Network focused on Access and Quality. Organizing 32 tertiary care/university programs, representing seven condition-specific programs (Behavioral Health, Craniofacial, Endocrine, Chronic Kidney, Hematology-Oncology, HIV/AIDS and Pulmonary), quality improvement (QI) teams from each condition-specific program are joined with their peers from other organizations, to collaborate and collectively work on condition-specific quality improvement projects.

QI teams are supported by training, coaching and peer-to-peer learning in QI methods through a series of quarterly virtual-QI learning sessions, monthly collaboration meetings, office hours for 1:1 technical assistance, all supported by an online platform for data and resource sharing amongst stakeholders. QI teams are guided in the development and testing of small tests of change using the Plan Do Study Act (PDSA) cycle and model for improvement. This resulted in seven-condition specific SNAQ-wide (i.e. across institutions) projects and 32 individual institution QI projects. Since the LAN's inception two years ago, over 100 PDSAs have been developed. For the next planned iteration of this continuous QI journey, steps include developing a LAN health equity framework for improvement, exploring return on investment for impact, and exploring health outcomes impact such as decreased emergency room visits and decreased hospitalizations. Highlights from each condition-specific SNAQ are highlighted below.

- Three diabetic organizations came together with the QI goal to improve diabetes care in school. Their project included launching a website that includes webinar and education materials. Measures included their website reaching 29 counties and 33 states, and their webinar having over 108 participants. The completed knowledge assessment by participants, indicated more than doubled knowledge across 4 measures in unlicensed staff, with overall increases in all 4 measures also occurring for licensed staff. Next steps include incorporating measurements

for confidence and adverse event occurrence.

- For pulmonary, two organizations worked to improve pulmonary care in schools. Their QI project included two completed training sessions, and measures demonstrated increase in trainees' comfort and knowledge, which continued 1-month post-training. Next, they will expand the spread and reach of the training.
- Five Hematology-Oncology organizations came together to improve sickle cell transition to adult care. Their QI project focused on the development of a relationship/network of adult providers willing to receive transitioning young adults with sickle cell. Measures included the number (N=55) of providers willing to participate, with qualitative identification of barriers. Next steps for the QI project include assessment of barriers, building capacity and developing collaborative partnerships with willing adult providers, and adding measurement to assess knowledge gain.
- Working to empower transition into adulthood, five Craniofacial organizations implemented patient readiness assessments, utilizing a customized GOT Transition tool for the craniofacial population) for their QI project. Readiness Assessments were administered 80% of the time and feedback surveys were provided at 100% of discharges. In the upcoming year, they will implement the tool in all sites for statewide standardization, for both caregiver and youth readiness assessments.
- Looking at Health Literacy for HIV disease management for adolescents/young adults and their families, the HIV team's QI project resulted in the identification of a single health literacy assessment tool to be used across their 5 different organizations. Results included improved health literacy assessment scores at all sites. The next phase will include disseminating QR codes for patient and provider use, while continuing to use the health literacy tool.
- With the QI aim to increase immunization rates of children with chronic kidney disease, four chronic kidney disease centers worked together to complete a provider needs assessment, and as a result of what they learned developed educational handouts and a website. Next Steps include modification to educational materials based on feedback.
- Specific to Behavioral Health (BH), this was first year five academic institutions joined the LAN. Their QI project focused on increase screenings and BH referrals at the primary care level. Highlights included education to PCPs regarding screenings and referrals, with increases in both noted as a result. They are working on identifying additional collaboration opportunities for the upcoming year.

As part of the priority need for increased access to PCMH and primary care, family partnership is a focused inclusion area. For ESM 11.2, the focus was on the number of caregivers of CYSHCN in Florida who perceive themselves as a partner in their child's care, with the objective to increase this number 5% annually from the identified baseline for this reporting year. At the time of this report, the measurement of this performance objective had not yet occurred, although planning work on the strategies has begun. CMS is working to develop a survey to disseminate to their family partner organizations to establish the baseline, as a target to increase by 5% during the upcoming year.

Strategies 11.2.1 and 11.2.2 focus on the inclusion area of family partnership. The first strategy is to create a cohort of caregivers of CYSHCN that are educated and equipped to be a partner in their child's care; and the second is to leverage work with existing and potential partners to increase opportunities for families of CYSHCN to become family partners at the individual, community, and systems level.

Meetings have been held at least once a month with CMS Title V Regional Family Leaders to optimize their awareness and use of materials, as well as information from various webinars related to family engagement in their outreach efforts to providers and other stakeholder groups. A few examples of such resources are: a Back-to-School Decision Tool for families and providers, developed in collaboration with CMS-Title V, FL AAP, and Florida's Family Voices' state affiliate, the Family Network on Disabilities; Family Voices' Effective Family Partnerships resources, and their new Telehealth Toolkit for Families; AAP's "Bright Futures" resources for patient/family engagement and partnership.

The Statewide Family Leader researched and provided multiple evidence-informed resources regarding patient and family engagement in general, and more specifically as it relates to involvement at the clinical level for quality improvement efforts. These resources were then posted on a shared platform for the SNAQs to be able to access. As well, the Statewide Family Leader developed a new Patient and Family Engagement Roadmap, based on extensive literature review of current, evidence-informed journal articles, toolkits, and other related resources. The resources Roadmap is for all team participants in our SNAQ LAN and will be utilized in other capacities on both the provider and caregiver side in other program initiatives.

The Statewide Family Leader participates in multiple state and national level healthcare, disability, and family leadership boards, committees, and workgroups. Within each of these settings Title V-related information, surveys, and documents related to caregiver/patient and provider engagement and partnership are disseminated. In turn, her involvement with these organizations allows her to learn about and bring back resources for CMS. Regional Family Leaders also have connections

with local community groups within their areas and do the same. As items are provided within these groups, the opportunity increases for the resources to be further disseminated out to families and other stakeholders. These organizations are far-reaching, as our Statewide Family Leader currently participates with several state and national groups, boards and councils including AMCHP Family Delegate for Florida, and is a new alumnus of AMCHP's Leadership Lab.

The Statewide Family Leader, as well as all the Regional Family Leaders, are members of the Title V-funded Florida Family Leaders Network (FFLN). As part of their engagement in this network, they share state and national resources related to patient- and family-centered care, behavioral health, health care transition and other topics related to caregiver support and engagement. In turn, these resources are allowed for distribution out to further family and stakeholder circles by the over 250 FFLN members from across the state.

For NPM 11, CMS partners with the University of Central Florida's Health Advancing Resources to Change Health Care (UCF HealthARCH), Florida's only designated National Committee for Quality Assurance (NCQA) partner in quality. UCF HealthARCH provides 1:1 technical assistance and support to pediatric practices regarding PCMH practice transformation, preparing them for NCQA Certification. Over the past four cohorts (2017-2020), 45 practices have received PCMH Recognition. There continues to be 40 practices (Cohort 4 was during the Pandemic and accounts for 33 of the practices in process) still in the recognition process, recently joined by 36 additional providers in the new Cohort 5 which commenced July 1, 2021. The goal is to have 224 PCMH recognized practices by the year 2025. ESM 11.3 was created to track the percentage of providers in underserved geographic areas that received formal technical assistance through UCF HealthARCH and become designated PCMHs, with the performance objective to increase the percentage of underserved geographic areas that have at least one pediatric practice that is designated as a PCMH by 20% at the end of the five year period. Challenges, referenced below, contributed to not being able complete the measurement of this objective at the time of this report. However, measurement will occur for subsequent reporting years.

Strategy 11.3.1 is to create a pipeline of providers that are engaged in enhancing their practice sites based on the foundational principles of PCMH, with health equity, workforce, and essential public health services as focused inclusion areas. Activities completed under this strategy included Geomapping current pediatric PCMH's services CYSHCN, to identify underserved communities and populations to monitor and evaluate the numbers and geographic locations annually. Title V regional specialists conducted outreach to identify practice type, number of providers, PCMH certification, and patients served. This information was then mapped geographically to identify gaps in access to care. Over 56.24% of practice type data revealed that 30.56% of providers identified as Family Practice and 25.68% as Pediatrics. Other practice types included: Internal Medicine (16.79%), Federal Qualified Health Centers (13.63%), Multi-specialty (13.20%), and Free or reduced cost clinic (0.14%). Per capita income was overlayed on the provider map that demonstrated that lower per capita income areas also had little or no providers and were located in less populated areas. While first generation PCMH maps were created, it was subsequently determined that transitioning to different mapping software would be more advantageous including the ability overlay various mapping activities that had been planned, such as behavioral health resources mapping and the vulnerability population index that is being created. The updated maps, using R studio, are currently in development.

In working to create a pipeline of providers that are interested in participating in PCMH transformation with UCF HealthARCH, CMS Title V regional specialists provided community outreach or education to 1,847 primary care providers. For providers that indicate interest CMS Title V specialists conduct a PCMH readiness assessment, developed in collaboration with UCF HealthARCH. The readiness assessments are reviewed by UCF HealthARCH to stage the practice for the most appropriate PCMH transformation activity. This past Spring, 28 readiness assessments were completed by Title V specialists which assisted UCF HealthARCH in identifying the 36 pediatric practices needed for the upcoming cohort for 1:1 PCMH transformation assistance. This year, during the early portion of the recruitment phase for the upcoming cohort, primary care providers reported that because of COVID-19, they had new competing priorities, and less than usual resources, which contributed as barriers to participate in this initiative. Therefore, it was challenging to engage providers that were interested and available to participate and subsequently the entire state was targeted for this outreach, not just underserved geographic areas as originally intended. In addition, for the practice cohort already engaged with UCF HealthARCH it has taken them longer than usual to get through the PCMH transformation process. As both of these cohorts complete their PCMH certifications, their practice location will be mapped and practices in underserved geographic areas will be tracked for both 2020 and 2021 data.

In moving towards more of a population health approach with UCF HealthARCH, the development of a learning action (LAN) model was also delayed due to COVID-19 and will be addressed in the upcoming year. PCMH readiness assessments are used to gauge appropriateness for the next PCMH cohort, which received 1:1 technical assistance, or participation in a LAN model which will assist in moving the practices further along in readiness for consideration of the next 1:1 cohort. It is anticipated that this model will eventually help shorten the duration of 1:1 technical assistance and allow more providers to

be served. The LAN will consist of six to eight virtual trainings to introduce and review the six core components needed to become a PCMH. Open offices hours will be offered to provide additional technical assistances to providers as they work towards PCMH transformation. Title V specialists will participate in the LAN activities, increasing their skills and capacity to provide further 1:1 technical assistance themselves, in the support and sustainability of practices in their area, an identified challenge for UCF HealthARCH as this initiative has grown over the past four years.

Transition for CYSHCN continues to be an important inclusion strategy that is imbedded in Florida's CYSHCN Action Plan. ESM 11.4 addresses the known transition barrier of the number of Adult Care Providers/Practices that accept CYSHCN transitioning to adult care, with the performance objective to increase the number of identified Adult Care Providers/ Practices PCMHs that will accept CYSHCN transitioning to Adult Care by 15 annually. As a result of COVID staffing priorities included public health missions, CMS was unable to determine the baseline for this measure. As transition has been a long standing initiative in Florida, the Title V team continues to recognize the significant impact of adult systems of care on this population, this strategy will continue this coming year, although a new approach to measurement collection will need to be identified, as it was determined that the current approach is not sustainable long-term

Strategy 11.4 is to work with other Title V CYSHCN Programs and internal Department of Health colleagues to identify and implement activities that will increase the numbers of family practice and adult providers that serve young adults with special health care needs did not occur. Prior to COVID-19, Florida participated with the other "big-five" populous states to collaborate on evidenced-based or informed strategies to increase the numbers of adult providers and practices that have the knowledge and capacity to care for young adults with special health care needs. It is hoped this collective effort will be picked up in the upcoming year. COVID-19 also stalled planning conversations with Got Transition, our national Transition Partner, Title V and the CMS Plan for a pilot project aimed to increase the percent of 18 to 21-year old members who transition from a pediatric provider to an adult care provider through a value-based payments model. Planning has recently resumed, and elements of the project include coordinated exchange of current medical information, plan of care, communication between pediatric and adult providers, and facilitated integration into adult care consistent with Got Transition's Six Core Elements of Health Care Transition.

Title V specialists completed 442 transition outreach or education activities, which included promoting Got Transition's Six Core Elements of Healthcare Transition. In addition, all condition-specific (e.g. HIV, Pulmonary, Diabetes) SNAQ programs received transition education. As part of their contract deliverables, all SNAQ programs submitted their transition processes and policies. These were reviewed through the lens of the Six Core Elements of Health Care Transition, and benchmarked in the form of a report card, which will be tracked annually with technical assistance provided on what they can do to increase their score. It was noted that an area of improvement across all contracts would be to assess successful transition after youth has landed safely with new provider. Creating an exit interview that would be sent to the youth after the initial appointment with new provider would be a recommendation to help assess this. Currently six SNAQ programs are focused on health care transition as a quality improvement project. Out of the six, two are working directly on Heath Care Transition-including Cleft Lip and Palate/Craniofacial and Hematology-Oncology programs. The HIV program is working on improving health literacy, which will also assist youth with their transition to adult health.

CMS researched other state's CYSHCN transition programs activities and evidenced-based or informed transition approaches in their planning to develop a request for proposals for a statewide youth led transition council. It is anticipated that this method will provide a leverage opportunity with existing groups/resources, maximizing efforts and most importantly incorporating active youth voice into transition program planning, policy development, strategies, and activities. Through Title V, the Jacksonville Health and Transition Services program (JaxHATS) continues to provide clinic services and skill- building strategies to transitioning youths.

CMS received notification that it was losing its long-time contracted state transition program (FloridaHATS) and efforts this year have focused on planning to bring the transition program in-house for Title V to operate directly. FloridaHATS vast website of materials, resources and tools have been reviewed to determine current needs and migration to CMS's website. Plans include updating CMS's current website design to enhance public interface with rebranding of the transition program being considered. A new transition education module for health care providers has been designed and is in development. This project was facilitated by Title V and done in collaboration with Florida's MCH partners and transition experts. It is hoped that this project will be released, in conjunction with the updates to CMS's new transition website.

For the identified priority need of access to behavioral (mental health) health services, Florida's State Performance Measure (SPM) includes the percent of children who need mental health services that actually receive mental health services. This is aligned with NOM 18 the percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling.

To maximize efforts similar to EMS 11.1, ESM 1.1 represents the number of FDOH team members, providers, (pediatric, family practice, and adult), families, family partners, and community service providers receiving education or technical assistance about accessing or providing access to behavioral health services, with the performance objective to increase the annual target each year. This year's performance objective target was 1000, but due to Title V specialists being diverted to public health mitigation and recovery efforts that threshold was not reach as indicated below. However, the ESM continues to align with the priority need and it is anticipated that future year targets will be achieved.

Strategy 1.1.1 is to identify, evaluate, and enhance education and technical assistance provided to FDOH team members, providers (pediatric, family medicine, and adult), families, family partners, and community service providers regarding accessing or providing access to behavioral health services and related topics that impact behavioral health and wellness. Inclusion areas are family partnership, health equity/social determinants of health, essential public health services, and life course/cross cutting.

Title V regional specialists provided outreach or education on the priority need for access to pediatric mental health treatment and the value of primary care integrating behavioral health services in their practice to 735 providers or community stakeholders. As part of this effort, practices are asked to report their level of behavioral integration which is measured against CIHS standard framework for levels of Integrated Healthcare. Of the practices reporting (N=442) having some level of BH integration, the majority (N=349 or 79%) included only basic coordinated behavioral efforts, with much smaller percentages indicating co-located (N=50 or 11.3%), or fully integrated (N=43 or 9.7%) BH practices.

ESM 1.2 includes the number of traditional and non-traditional providers that have initiated integrating behavioral health services, with the performance objective to increase the number 3% annually from baseline. As the strategies under this ESM have interconnected and building activities, the activities reported includes a summation for the following strategies: 1.2.1 Identify, develop, and disseminate resources for change management for traditional and non-traditional providers to begin behavioral health integration; 1.2.2 Leverage work with existing and potential partners to increase the accessibility and utilization of needed behavioral health services; 1.2.3 Create a pipeline of providers that are engaged in enhancing their practice sites by improving behavioral health awareness, prevention, identification and treatment. Activities this year include behavioral health system mapping for about half of the counties in the state, with the other half expected by the end of the calendar year. These maps can then be integrated with other mapping activities, such as PCMH and the vulnerability population index, and used to prioritize underserved areas. Business Intelligence reports and overlaying various system maps will assist in comprehensive system analysis for gaps and needs.

CMS's major initiative includes the evidenced-based practice of Behavioral Health Integration (BHI) in the pediatric primary care setting. For this strategy, CMS contracts with five university partners across the state (University of South Florida, Florida State University, University of Florida, University of Miami and Florida International University) to operate as regional pediatric mental health access programs, known as behavioral health hubs (BHH). National guidelines, frameworks (such as the Center of Excellence for Integrated Health Solutions) and evidenced based practices steered the development of regional BHH contract tasks, which includes a strong emphasis on quality improvement activities. The BHH's are responsible for partnering with pediatric primary care practices, currently at 19, and behavioral health organizations in their area with the aim of improving identification and treatment of children with behavioral health needs by increasing pediatric primary care providers knowledge and confidence through skill building training, technical assistance, and the availability of expert mental health clinicians to help support management of behavior health conditions in primary care settings and needed access to care including telehealth. This year the BHH's provided 22 trainings to a combined total of 199 participants whose disciplines included Pediatricians, Psychiatrist, Psychologist, Advanced Practice Nurse, Registered Nurses and Social Workers.

The regional approach of the BHH's allows for diversity in the specific design on the model based on the needs and resources of the community. A common core data set was developed for tracking and measurement both within and across the BHH's, with external evaluation services provided through a contract with the University of South Florida. The five regional BHHs and statewide pediatric psychiatric consultation hotline, form a statewide network of pediatric mental health access programs entitled the Florida Pediatric Mental Health Collaborative (FPMHC). Facilitated by CMS Title V, the FPMHC meets virtually, once a month, and includes state agencies such as Department of Children and Families: Substance Abuse and Mental Health and Agency for Health Care Administration's Medicaid Program; family representatives from the National Alliance on Mental Illness and other stakeholders. This venue provides an opportunity for learning and sharing of information to assist with quality improvement, address needs or challenges including sustainability. As a result of COVID-19, the need to address children's emotional wellbeing and mental health has been magnified, currently BHHs represent only five out of the intended seven regions in Florida. Title V is actively seeking additional funding opportunities including recent application

to HRSA's Pediatric Mental Health Access Program expansion grant to help ameliorate this need.

ESM 1.3 represents the number of activities identified that support families in enhancing mental health protective factors and build resilience, with the performance objective to increase the baseline by 3 annually. Strategy 1.3.1 is to identify, develop, and disseminate resources for traditional and non-traditional providers, as well as community partners, on available activities and resources that enhance mental health protective factors and build resilience in the families they are serving. In addition, strategy 1.3.2 leverages work with existing and potential partners to increase activities for families that enhance mental health protective factors and build resilience.

This year CMS established a vetting process for resources that are identified by various team members for potential dissemination. This includes a multi-disciplinary team, that includes lived-family perspective, to review and ensure resources are evidenced based, current, aligned with core public health essential services and relevant to Title V priority or emerging needs before they are then disseminated to community partners. This, specific to support enhancing mental health protective factors for families 24 resources were identified, as a baseline, and made available to Title V specialists for dissemination to stakeholders. The resources included a variety of mediums including articles, infographics, webinars, and websites. Resources used were from regional or state organizations as well as national organizations, such as Bright Futures. Five of the resources were specific to COVID-19 and included AAP's Caring for CYSHCN during the COVID-19 Pandemic. Plans include a focus on the identification of more community or state activities or supports, and not just resources, as part of this strategy. This year potential partnership development planning with FSU's Center for Prevention and Early Intervention Policy was stalled due to resource challenges. As CMS remains active with multiple state and community partner collaborations, additional leverage opportunities that are fiscally neutral will continue to be surveyed in support of strategy 1.3.2.

CMS worked with Mercer, a national consulting company, to collaborate with Florida's system stakeholders for Medical Foster Care and Specialized Therapeutic Foster Care programs to develop a white paper in consideration of building a "dual" program to serve foster care children that have both medical and therapeutic needs. This included surveillance of similar programs in other states and interviews with AHCA's Medicaid program, Department of Children and Families Child Welfare programs and local systems of care that had started dual homes in their community. The white paper will be shared with partners to further examine opportunities to address this identified need.

Children with Special Health Care Needs - Application Year

Complementing the five-year needs assessment process for CYSHCN, regional needs assessments are done annually. This helps ensure sensitivity to regional needs or trends, and emerging issues. In addition, strategies under each of the priority need sections include “and related topics that impact health and wellness of CYSHCN”. Subsequent activities allow for the opportunity to identify, and address training needs or gaps in knowledge.

For the upcoming application year, the annual regional needs assessment results confirmed the identified priority needs for CYSHCN. In addition, community health data showed troubling trends with asthma hospitalization rates across many communities. As a result of this information, CMS was able to seamlessly incorporate this supplemental need under a PCMH strategies and activity and in-turn leveraged resources to start a workgroup to look at training needs, evidenced based strategies and educational materials to help disseminate to PCPs and community partners.

This year, the CYSHCN team will continue its existing activities as outlined in their action plan, while implementing or staging new activities. While not a specifically called out priority area, transitioning from pediatric to adult systems of care continues to be an important component and is incorporated into the medical home and behavioral health priority areas.

Last year’s application brought about new Performance Objectives (PO), Evidence-Based Strategy Measures (ESM) and State Outcome Measures (SOM) to better assist CMS in improving its program’s performance through results-based accountability. Each PO has an affiliated ESM and SOMs were developed to capture satisfaction with access to care in each of the priority needs.

CYSHCN staff plan to initiate or continue the following activities, organized by aligned strategy and priority need:

Priority Need: Increase access to medical homes and primary care for children and youth with special health care needs

Strategy 11.1: Identify, evaluate, and enhance education and technical assistance provided to FDOH team members, providers (pediatric, family medicine, and adult), families, family partners, and other partners serving children and youth with special health care needs (CYSHCN) regarding the patient-centered medical home model and related topics that impact the health and wellness of CYSHCN

11.1.a.i: Identify training needs/gaps in knowledge for FDOH team members, providers, families, and other partners serving CYSHCN, this continues to be in progress and will continue for this application. In addition to PCMH topics, other related topics that have been identified as training needs and gaps include asthma, bullying and oral health will be areas that are included in the upcoming application.

11.1.a.ii: Identify or develop additional educational materials and trainings to meet the needs/gaps in knowledge identified for each audience listed in activity 11.1.a.i, incorporating evidence-based strategies and interventions as available, will continue for this application. This will include an updated transition education module for clinicians.

11.1.a.iii: Define measurements of success/outcomes for educational materials provided and trainings and set benchmarks for each will be an activity that will be picked up for this application year.

11.1.a.iv: Integrate Public Health Core Competencies, Public Health Core Functions, and the Maternal and Child Health pyramid in trainings for audiences as needed is an ongoing activity that will continue.

11.1.a.v: Provide evidenced based and evidence-informed education and technical assistance is an ongoing activity that will continue.

11.1.a.vi: Continue to engage various condition specific provider groups serving CYSHCN, through a learning collaborative approach to share best practices, focus activities on strengthening the system of care for CYSHCN and their families utilizing the Standards for Systems of Care for Children and Youth with Special Health Care Needs, version 2.0, and work together on quality improvement projects to improve the health and wellness of CYSHCN and their families. This is a robust activity that will continue with additional groups anticipated for the application year.

11.1.a.vii: Provide 6 trainings that address the strategic skills needed to advance the patient-centered medical home initiative with pediatric providers is an activity that will be staged this year in anticipation of implementation. This activity will help expand the reach of PCMH practice transformation offering a learning action network to better equip pediatric providers in becoming PCMHs.

11.1.a.ix: Track the number of providers that move to UCF HealthARCH activities as a result of interaction with an educational opportunity or training will be a continued activity.

11.1.a.x: Track the number of families that move to formal “family partner” activities as a result of interaction with an educational opportunity or training is an activity that will be started this year.

11.1.a.xi: Continue to encourage the utilization of quality of life tools and measures and track partners that have incorporated such tools and measures into practices.

11.1.b.i: Research evidence-based strategies to inform education and outreach activities to assist practices in identifying and addressing social determinants of health as well as strategies for health promotion (including behavior change) in CYSHCN utilizing the life course framework for cross cutting impact across Maternal and Child Health populations will be a continued activity.

11.1.b.ii: Generate an underserved report that includes CYSHCN as well as populations known to the Medical Foster Care and the Children's Multidisciplinary Assessment Team Programs has been in the planning stages and will be implemented in the application year.

11.1.b.iii: Identify communities for targeted education and outreach based on the underserved report, is anticipated to come to fruition this coming year, with the completion of the underserved report and geo-mapping activity.

11.1.b.iv: Title V Consultants provide training to the Title V Specialists on the content and delivery of the education and outreach strategies related to 11.1.b.i. and 11.1.b. ii will also move forward for this application.

Strategy 11.2.1 Create a cohort of caregivers of CYSHCN that are educated and equipped to be a partner in their child's care

11.2.1.a.i: Title V Family Leaders and other family partners will convene a workgroup of caregivers of CYSHCN to learn about needs related to the provider/patient partnership will continue as an activity.

11.2.1.a.ii: Research current outreach documents for caregivers on the topic of enhancing patient/provider partnerships in a medical home or integrated behavioral health home will remain for the upcoming year.

11.2.1.a.iii: Use current available resources or develop a one-page tip sheet and other resources identified through the workgroup in 11.2.1.a.i. in understandable terms for caregivers to enhance the provider/patient partnership in a medical home or integrated behavioral health home will also be continued.

Strategy 11.2.2: Leverage work with existing and potential partners to increase opportunities for families of CYSHCN to become family partners at the individual, community, and systems level

11.2.2.a.i: Continue to support Family Organizations in Florida in their efforts of educating and supporting families with CYSHCN.

11.2.2.a.ii: Identify other organizations that support families, family partnerships, and the utilization of the PCMH model to determine collaboration opportunities.

Strategy 11.3.1: Create a pipeline of providers that are engaged in enhancing their practice sites based on the foundational principles of patient-centered medical homes.

11.3.1.a.i: Geomap current PCMH's serving pediatrics, CYSHCN, including Children with Medical Complexity to identify underserved communities and populations will be accomplished this application year.

11.3.1.a.ii: Monitor and evaluate the numbers and geographic locations of PCMH sites annually.

11.3.1.b.i: Continue to identify providers/practices interested in becoming PCMH certified. (including providers that may fill gaps identified from activity 11.3.1.a.i).

11.3.1.b.ii: Title V Specialists will conduct assessments and share data with UCF HealthArch to identify practice sites ready for transformation and for other practice sites that are not ready for transformation.

11.3.1.b.iii: Increase outreach efforts in order to identify 36 pediatric /Family providers/practices annually that are interested in becoming PCMH Certified and have been assessed for readiness.

11.3.1.b.iv: Implement a Learning Action Network for pediatric/adult providers/practice sites that are not yet ready for PCMH transformation, but that would like to learn best-practices for creating a PCMH-like practice will be in the installation phase moving toward initial implementation by the end of the application year. This activity will be accomplished, in part, through a partnership with the University of Central Florida's (UCF) Health ARCH (Advancing Resources to Change Healthcare).

Strategy 11.3.2: Leverage work with existing and potential partners to increase the spread of patient-centered medical homes.

11.3.2.a.i: Support the Agency for Health Care Administration in their efforts of increasing PCMH utilization.

11.3.2.a.ii: Identify other organizations that support the utilization of the PCMH model to determine collaboration opportunities.

11.3.2.a.iii: Continue to explore partnerships with organizations that will increase the capacities of PCMHs to be a part of Patient Centered Medical Neighborhoods.

Strategy 11.4: Work with other Title V CYSHCN Programs and internal Department of Health colleagues to identify and implement activities that will increase the numbers of family practice and adult providers that serve young adults with special health care needs.

11.4.a.i: Collaborate with the "Big five" most populous states which includes Florida to identify evidence-based or evidence- informed strategies to identify and increase the numbers of adult providers and practices that have the knowledge and capacity to care for young adults with special health care needs

11.4.a.v: Form a Youth Council/Coalition and identify Youth Champions that can give a deeper insight into their perspective on transition issues and can mentor those approaching transition.

11.4.1.a.vi: Conduct a series of listening sessions to gather information and insight from young adults with special health care needs related to accessing providers and supports needed for optimal health, wellness, and quality of life.

Priority Need: Increase access to behavioral health services

Strategy 1.1.1: Identify, evaluate, and enhance education and technical assistance provided to FDOH team members, providers (pediatric, family medicine, and adult), families, family partners, and community service providers regarding accessing or providing access to behavioral health services and related topics that impact behavioral health and wellness.

1.1.1.a.i: Identify or create online Parent Training Webinars on "How to Navigate" the mental health system of care will start this application year.

1.1.1.a.ii: Train PCP's, FDOH team members, and MFC parent providers on Trauma Informed Care and effective behavioral health management strategies and other identified behavioral health related topics will also start this application year.

1.1.1.a.iii: Disseminate developmentally appropriate information to providers, communities and families to increase awareness of behavioral health resources across the lifespan will continue.

1.1.1.a.iv: Educate providers and families on GOT transition's 6 core elements to support behavioral health transitions.

1.1.1.a.v: Train providers in cultural competency and family engagement strategies.

1.1.1.a.vi: Track the number of providers that move to integrating behavioral health activities as a result of interaction with an educational opportunity or training.

Strategy 1.1.2. Collaborate with organizations on existing or developing Public Awareness Campaigns to increase awareness of mental health and reduce stigma.

1.1.2.a.i: Design a Marketing strategy and training method to increase outreach activities, including communication skills training.

1.1.2.a. ii: Collaborate with families to create an evidence-based or evidence-informed public awareness campaign to increase awareness of mental health and reduce stigma.

1.1.2.a.iii: Organize community events and provide behavioral health education to reduce stigma, increase behavioral health awareness, importance of early identification and improve access to treatment.

Strategy 1.1.3 Leverage work with existing and potential partners to increase awareness, prevention identification, treatment activities, and treatment resources.

1.1.3.a.i: Collaborate with State and community partners to educate on behavioral health early screening and anti-stigma activities will continue.

1.1.3.a.ii: Collaborate with State and system stakeholders such as DCF, AHCA, FL AACAP, FL AAP & Children's hospitals to support behavioral health Initiatives will continue and include DJJ and DOE.

1.1.3.a.iii. Support a cross-organization initiative to roll out a statewide centralized repository for behavioral health resources and information, including SDoH will be accomplished by supporting Florida' First Lady's Hope for Healing website, which is inclusive of MyfloridaMyFamily and Aunt Bertha services and the Substance Abuse and Mental Health Services Administration's (SAMHSA) Behavioral treatment services locator.

1.1.3.a.vii. Collaborate with partners to increase the availability and capacity of medical-therapeutic homes (foster care).

Strategy 1.2.1: Identify, develop, and disseminate resources for change management for traditional and non- traditional providers to begin behavioral health integration

1.2.1a.ii: Utilize System Mapping to discover behavioral health resources for providers, communities and families, as well as to identify gaps and needs.

1.2.1a.iii: Continue to partner with University, State and community stakeholders to expand capacity for behavioral health services in identified rural and underserved communities.

1.2.1a.iv: Incorporate technology to improve access to behavioral health education, screening, and treatment in rural and underserved areas.

Strategy 1.2.2: Leverage work with existing and potential partners to increase the accessibility and utilization of needed behavioral health services.

1.2.2. a.i: Improve communication between providers and the mental health community through partnership development.

1.2.2.a.ii: Collaborate with government agencies, insurance companies, academic institutions, school systems, associations and other organizations to improve access for needed behavioral health services for families, including transition-related needs.

1.2.2.a.iv: Continue to partner with University, State and community stakeholders to implement evidence-based models of behavioral health integration in primary care or other identified care settings.

1.2.2.a.v: Continue to leverage established behavioral health hubs to partner with practices and to facilitate increasing access to care.

Strategy 1.2.3: Create a pipeline of providers that are engaged in enhancing their practice sites by improving behavioral health awareness, prevention, identification and treatment.

1.2.3.a.i: Identify practice sites to participate in practice site improvement.

1.2.3.a.ii: Survey identified practice sites regarding integrated behavioral health (IBH) needs and knowledge deficits.
1.2.3.a.iii: Create a learning collaborative based on survey results from 1.2.3.a.ii.

1.2.3.a.v: Create a workgroup that will research, conduct focus groups, and listening sessions to identify key components needed by Florida providers for steps to integrate behavioral health into primary care settings.

Strategy 1.3.1: Identify, develop, and disseminate resources for traditional and non-traditional providers, as well as community partners, on available activities and resources that enhance mental health protective factors and build resilience in the families they are serving.

1.3.1a.i: Utilize System Mapping to discover available resources, as well as to identify gaps and needs.

Strategy 1.3.2: Leverage work with existing and potential partners to increase activities for families that enhance mental health protective factors and build resilience.

1.3.2.a.i: Improve communication between families, providers and the mental health community through partnership development will continue.

1.3.2.a.ii: Support organizations in Florida in their efforts to provide activities and supports for families, such as parenting classes and support for financial activities including tax preparation assistance.

1.3.2.a.iii: Identify other organizations that support healthy families and health neighborhoods.

Cross-Cutting/Systems Building

Cross-Cutting/Systems Builiding - Annual Report

The health of families is one of Florida's most important priorities. The foundation of a family begins with the health of the parents. The Florida Department of Health (FDOH) recognizes that mental health is a key component to overall health. To address the need for behavioral and mental health services in Florida, the MCH Section applied for and was awarded a grant from the Health Resources and Services Administration (HRSA): *The Development of a Sustainable Screening and Treatment Model to Improve Maternal Mental Health Outcomes in Florida*.

The goal of this grant from HRSA, known as BH IMPACT: Improving Maternal and Pediatric Access to Care and Treatment for Behavioral Health, is to increase routine screening and referral by prenatal care providers. The project team developed and implemented a perinatal screening and treatment model to directly train health care providers in prenatal health care practices and birthing hospitals. Community mental health providers will be trained in evidence-based management of perinatal mental health disorders and have access to a professional perinatal psychiatrist for consultation to increase the use of evidence-based therapeutic interventions for perinatal depression. Mental health and substance abuse referral networks have grown through provider outreach, development of community resource guides, and expansion of the Moving Beyond Depression program in statewide home visiting programs.

Additionally, Florida was one of five states to be selected by the CDC and Association of State and Territorial Health Officers (ASTHO) for a site placement of a Maternal & Neonatal Opioid Prevention Coordinator to support the Opioid, Maternal Health, and Neonatal Abstinence Syndrome Initiative (OMNI). The coordinator's role was specifically designed to support the MORE project by identifying and drawing together stakeholders in communities with high rates of NAS to help connect resources, identify system barriers, and share insights, gaps, and lessons learned with the broader Florida Neonatal Abstinence Syndrome (NAS) stakeholder group.

In the first five months of the project, our coordinator met with state teams and visited or conducted virtual meetings with 18 counties to meet with local leaders and learn about their biggest challenges in addressing OUD among pregnant women. Most of these counties have hospitals in the MORE initiative, the others either requested a meeting or were otherwise a high-need county. Meetings were structured around a framework designed to identify current needs, system barriers, relationship strengths, and areas that communities self-identified as areas where they needed help to improve.

Several issues rose to the top in most communities, including challenges with implementing SBIRT, identifying sufficient MAT providers (especially for buprenorphine), getting women to accept treatment once the need had been identified, and not knowing where to refer pregnant or postpartum patients for care. The coordinator initiated and started facilitating MAT workgroup meetings that could address some of these concerns. This workgroup includes partners from the Florida Hospital Association, FPQC, and AHCA. We have brought together these partners as well as Healthy Start in a coordinated effort to address many of the challenges faced in each community, taking care to highlight best practices in collaboration at the community and hospital level.

The FDOHs Violence and Injury Prevention (VIP) Section plays a key role in the development of the state's suicide prevention plan; the Governor's Challenge action plan to address suicide among services members, veterans, and their families; the Governor's Youth & Children Cabinet Information Technology Work group, and the State Health Improvement Plan's Behavioral Health Priority Area Workgroup goals and objectives.

VIP works closely with the Department of Children and Families (DCF), home to the Statewide Office of Suicide Prevention (SOSP) and the state's lead designated agency for Substance Abuse Mental Health Services Administration (SAMHSA) funding. DCF works with the Florida Association of Managing Entities (FAME), a system-wide behavioral health network. Managing Entities (MEs) contract regionally with providers on behalf of DCF. The MEs do not provide direct services; rather, MEs contract with local, direct service providers, tailoring to the specific behavioral health needs in communities. DCF and FAME coordinate efforts with Florida Suicide Prevention Coalition, the nonprofit organization representing local suicide prevention coalitions throughout the state. The Florida Suicide Prevention Coalition is responsible for the annual statewide suicide prevention conference, held in the Spring. The FDOH has presented at the conference two of the last three years.

Cross-Cutting/Systems Building - Application Year

The School Health Services Program is implementing a one-million-dollar grant for the 2021-2022 school year under the Substance Abuse and Mental Health Services Administration to implement evidence based trauma mental health training in schools affected by Hurricane Michael including the counties: Jackson, Calhoun, Liberty, Bay, Gulf and Gadsden. The School Health Services Program will work with the National Center for School Mental Health at the College of Medicine of the University of Maryland to implement the evidence-based curriculum. The effectiveness of the training will be evaluated by the SHAPE system, a program developed by the National Center for School Mental Health to determine the effectiveness of mental health services in schools.

As many as one-third of women with Opioid Use Disorder have a comorbid mental health condition such as depression, anxiety, or other diagnoses, making treatment more complex as both the substance use and concurrent mental health issues must be treated at the same time. Florida has a shortage of obstetricians and other primary care providers for pregnant/postpartum women who are trained to screen, diagnose, and treat and refer women with mental health and substance use disorders during pregnancy and in the post-partum period. Families often find it difficult to find and access services, and many women are unwilling to admit to substance use for fear that their prenatal care physician will no longer provide care. It is not uncommon to have pregnant women with OUD who must travel to neighboring counties, or even further, to find a provider who can treat them. We are working on strategies to make perinatal psychiatric support services more accessible to physicians so that they can continue to treat women in their own communities, rather than sending them an hour or more away for care. Telehealth programs are a promising approach, and a pilot model in Florida is already providing these services to physicians in specific counties. We hope to expand this model statewide.

The FDOH hired an Opioid Coordinator who continued the work of the ASTHO/OMNI grant mentioned above and collaborate with the BH IMPACT project as well to help meet the substance use and mental health needs of pregnant and post-partum women. The coordinator's role was specifically designed to support the Florida Perinatal Quality Collaborative's Maternal Opioid Recovery Effort (MORE) project by identifying and drawing together stakeholders in communities with high rates of NAS to help connect resources, identify system barriers, and share insights, gaps, and lessons learned with the broader Florida Neonatal Abstinence Syndrome (NAS) stakeholder group. This includes initiating a MAT workgroup. This workgroup includes partners from the Florida Hospital Association, FPQC, and AHCA. We have brought together these partners as well as Healthy Start in a coordinated effort to address many of the challenges faced in each community, taking care to highlight best practices in collaboration at the community and hospital level.

The FDOH will continue their efforts related to the perinatal mental health grant from HRSA, BH IMPACT. The purpose of the project is to develop a sustainable screening and treatment model to improve maternal mental health outcomes in Florida. Over the five-year grant period the team members will work to achieve the following overarching goals:

- Build capacity in Florida to fully and competently deliver all aspects of screening, referral, engagement, and mental health consultation trainings to all major obstetrics practices and birth hospitals in the targeted region.
- Build and implement a screening and treatment model for maternal mental health in all major prenatal health care practices in the targeted region.
- Develop and implement training program for obstetrics providers on tool use, follow up, and the Massachusetts Child Psychiatry Access Program (MCPAP) model; develop and refine the psychiatric consultation model.
- Initiate and maintain provider participation and engagement in the program.
- Expand mental health and substance abuse referral networks in the regions.
- Increase statewide maternal mental health resources and capacity.
- Increase access to screening, referral, and treatment for women in rural and non-rural areas through telehealth resources.
- Train community mental health providers in evidence-based psychotherapy and management of perinatal mental health disorders.
- Develop and implement a State Data Dashboard System.

The VIP Section will continue their suicide prevention efforts. The Department of Children and Families (DCF) also facilitates the Suicide Prevention Coordinating Council (SPCC). Established by Florida statute, the SPCC meets quarterly and advises the Office of Suicide Prevention and provides annual recommendations to the legislature of top priorities for preventing suicide. The State Surgeon General is a Council member. Meetings are also attended by the Bureau Chief of Family Health Services, who serves as the Surgeon General's alternate, and the Administrator of the VIP Section, also in the Bureau of Family Health Services, who has been recognized by the Committee as a permanent guest. The SPIAC is a workgroup

under the Council. Once the new state suicide prevention plan is implemented in the Fall of 2020, SPIAC will transition into the Strategic Plan and Evaluation Workgroup, tasked with tracking and measuring success of the state action plan goals, objectives and activities. The Council nominated the FDOH's VIP Section Administrator to continue in roleas Chair.

The Strategic Plan and Evaluation Group meets monthly. The VIP Section Administrator was also nominated to serve as Co-Chair of the Data Analysis Workgroup, which also meets monthly. The Data Analysis Workgroup identifies and links relevant data sources for suicide surveillance. The FDOH's Injury Epidemiologist is a member of this workgroup. The VIP Section Administrator also serves as a FDOH representative of the Veterans' workgroup. This SPCC workgroup iscomprised of participating members of the Governor's Challenge to Prevent Suicide Against Veterans, Service Members, and their Families. The final workgroup under the SPCC is Communications. The FDOH will request membership on this workgroup to align messaging.

Additional FDOH VIP partners include the Florida Department of Veteran's Affairs, the Department of Education, the Department of Elder Affairs, the Agency for Persons with Disabilities, the Florida Department of Law Enforcement, the Florida Council Against Sexual Violence and the Florida State University College of Medicine. University partners include the University of Central Florida, the contracted provider of Garrett Lee Smith Youth Early Intervention and Suicide Prevention grant, and includes, among their faculty, recognized experts in the Zero Suicide project. The UCF Center for Behavioral Health Research & Training is recognized by the SAMHSA Suicide Prevention Branch as an expert resource for the adapted version of the Zero Suicide strategy for public health departments. UCF is also a partner in the FL Implementation of the National Strategy for Suicide Prevention (FINS) Project, with the DCF State Office of Suicide Prevention, USF), and FloridaHospital. Using a mentorship model, FINS integrates the National Strategy for Suicide Prevention to ensure that health and behavioral health settings and adult-serving systems are prepared to engage and treat at-risk adults with culturally competent evidence-based/best-practice (EB/BP) suicide prevention, treatment, safety planning, and care coordination services. The goals of the project include: transform health and behavioral health systems infrastructure through the development of Zero Suicide advisory committees, suicide prevention policies and procedures, and the integration of EB/BP measures and mechanisms to monitor suicide care; enhance the collaboration of local and state-level partnerships to promote Zero Suicide and National Suicide Prevention Lifeline utilization; develop workforce training capacity to utilize EB/BP suicide prevention strategies; enhance care coordination strategies to increase the number of recovery and support linkages for at-risk adults to be sustained in treatment; improve the sharing, and tracking of suicide-related indicators (suicide ideation, attempts, deaths, and service utilization) via regional and state-level data surveillance systems.

State suicide data has been reviewed and five counties have been identified as having elevated youth suicide rates. The FDOH is contacting each county health department and discussing what programs and initiatives they are actively engaged in to address suicide in their communities and any identified barriers or challenges they are experiencing. The FDOH will then compile this feedback and look for any trends that can be addressed.

III.F. Public Input

The Maternal and Child Health Block Grant and needs assessment documents are available over the Internet on the FDOH's website. In addition, the FDOH created an MCH Block Grant email inbox dedicated to comments and suggestions regarding the block grant application. The block grant documents and the link to the inbox can be found at: http://www.floridahealth.gov/programs-and-services/womens-health/pregnancy/mch-block-grant.html.

In addition, the MCH Section solicits and receives ongoing feedback from our partners and the clients they serve. Many of our contracts have satisfaction surveys included as a means to learn more regarding direct client services and if these services are meeting the needs of the populations we serve. The MCH Section is exploring ways to expand this engagement and welcomes the chance to partner with families who have lived experience.

CMS utilizes its family organization partnerships for engagement of family feedback on needs and annual satisfaction surveys. During this reporting year, CMS coordinated public input related to COVID and CYSHCN with its Florida Family Voices state affiliate, the Family Network on Disability (FND). This resulted in survey information being disseminated through FND's strong social media presence and website. Feedback from this survey resulted in the co-development of Back-to-School Decision Tool for families and providers, that was later sponsored and disseminated through Florida's Chapter American Academy of Pediatrics, Florida's Family Voices' state affiliate, the Family Network on Disability and the University of Miami. Additional family organizations that CMS works with for family voice includes the Florida Family Leader Network and Family Café.

III.G. Technical Assistance

There are no current technical assistance needs identified.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - AA374 Agreement 2019.pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - AA348.pdf

Supporting Document #02 - FHB CHD Activity Summary Report with Infant Mortality Rates 2021 082021.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - DOH_ORG_CHART (3).pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Florida

	FY 22 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 20,767,711	
A. Preventive and Primary Care for Children	$ 6,268,063	(30.1%)
B. Children with Special Health Care Needs	$ 8,991,764	(43.2%)
C. Title V Administrative Costs	$ 1,318,400	(6.4%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 16,578,227	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 15,575,783	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 106,055,754	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 33,580,785	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 155,212,322	
A. Your State's FY 1989 Maintenance of Effort Amount $ 155,212,322		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 175,980,033	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 29,786,523	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 205,766,556	

OTHER FEDERAL FUNDS	FY 22 Application Budgeted
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 11,200,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Safeguarding Two Lives: Expanding Early Identification & Access to Perinatal Mental Health	$ 650,000
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education (SRAE)	$ 3,988,211
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 1,872,466
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventing Maternal Deaths: Supporting Maternal Mortality Review Committees	$ 450,000
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > School Health	$ 11,625,846

	FY 20 Annual Report Budgeted		FY 20 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 20,940,088		$ 19,837,392	
A. Preventive and Primary Care for Children	$ 6,779,315	(32.4%)	$ 6,098,286	(30.7%)
B. Children with Special Health Care Needs	$ 9,423,040	(45%)	$ 7,593,549	(38.2%)
C. Title V Administrative Costs	$ 1,861,533	(8.9%)	$ 1,402,266	(7.1%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 18,063,888		$ 15,094,101	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 155,212,322		$ 15,527,544	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0		$ 106,092,392	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0		$ 33,592,386	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 155,212,322		$ 155,212,322	
A. Your State's FY 1989 Maintenance of Effort Amount $ 155,212,322				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 176,152,410		$ 175,049,714	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 29,375,939		$ 25,338,492	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 205,528,349		$ 200,388,206	

OTHER FEDERAL FUNDS	FY 20 Annual Report Budgeted	FY 20 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education (SRAE)	$ 4,065,985	$ 3,500,000
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 12,030,000	$ 8,309,097
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 1,954,108	$ 1,553,549
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Safeguarding Two Lives: Expanding Early Identification & Access to Perinatal Mental Health		$ 650,000
US Department of Education > Other > School Health	$ 11,325,846	$ 11,325,846

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**5. OTHER FUNDS**
	Fiscal Year:	**2022**
	Column Name:	**Application Budgeted**
	Field Note:	After discussion with Ellen Volpe, this year I broke down the Maintenance of Effort figure to show the match amount, the program income amount and other funds.
2.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note:	Florida applied for $20,940,088 and budgeted for each category based on this. However, our actual award was $19,837,392 and category budgeted were adjusted accordingly.
3.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs:**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note:	Florida applied for $20,940,088 and budgeted for each category based on this. However, our actual award was $19,837,392 and category budgeted were adjusted accordingly.
4.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note:	Florida applied for $20,940,088 and budgeted for each category based on this. However, our actual award was $19,837,392 and category budgeted were adjusted accordingly.
5.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note:	Match is based on each year's application amount.
6.	**Field Name:**	**5. OTHER FUNDS**

	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: This year based on guidance from Ellen Volpe, we broke down the MOE into the amount for match, program income and other.	
7.	**Field Name:**	**6. PROGRAM INCOME**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: This year based on guidance from Ellen Volpe, we broke down the MOE into the amount for match, program income and other.	
8.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventing Maternal Deaths: Supporting Maternal Mortality Review Committees**
	Fiscal Year:	**2022**
	Column Name:	**Application Budgeted**
	Field Note: This is a new grant that we were just awarded.	

Data Alerts: None

Form 3a
Budget and Expenditure Details by Types of Individuals Served

State: Florida

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Pregnant Women	$ 4,189,484	$ 4,743,291
2. Infants < 1 year	$ 2,547,547	$ 2,415,558
3. Children 1 through 21 Years	$ 3,720,516	$ 3,682,728
4. CSHCN	$ 8,991,764	$ 7,593,549
5. All Others	$ 0	$ 0
Federal Total of Individuals Served	$ 19,449,311	$ 18,435,126

IB. Non-Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Pregnant Women	$ 30,943,037	$ 26,851,732
2. Infants < 1 year	$ 12,960,372	$ 21,729,725
3. Children 1 through 21 Years	$ 104,861,192	$ 100,183,144
4. CSHCN	$ 6,166,814	$ 7,323,940
5. All Others	$ 0	$ 0
Non-Federal Total of Individuals Served	$ 154,931,415	$ 156,088,541
Federal State MCH Block Grant Partnership Total	$ 174,380,726	$ 174,523,667

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

1.	**Field Name:**	**IA. Federal MCH Block Grant, 2. Infant < 1 Year**
	Fiscal Year:	**2022**
	Column Name:	**Application Budgeted**
	Field Note: The amount for Infants and the amount for children 1-22 = the amount of Form 2	
2.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1 through 21 years**
	Fiscal Year:	**2022**
	Column Name:	**Application Budgeted**
	Field Note: The amount for infants plus the amount for children 1-21 equals the amount on Form 2	
3.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1 through 21 years**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: The amount for infants plus the amount for children 1-22 equals Form 2	

Data Alerts:

- Children 1 through 21 Years, Application Budgeted does not equal Form 2, Line 1A, Preventive and Primary Care for Children Application Budgeted. A field-level note indicating the reason for the discrepancy was provided.
- Children 1 through 21 Years, Annual Report Expended does not equal Form 2, Line 1A, Preventive and Primary Care for Children, Annual Report Expended. A field - level note indicating the reason for the discrepancy was provided.

Form 3b
Budget and Expenditure Details by Types of Services

State: Florida

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Direct Services	$ 2,448,946	$ 2,464,327
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 815,107	$ 1,588,026
B. Preventive and Primary Care Services for Children	$ 1,633,639	$ 876,301
C. Services for CSHCN	$ 200	$ 0
2. Enabling Services	$ 12,504,583	$ 10,856,888
3. Public Health Services and Systems	$ 5,814,182	$ 6,516,177
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 1,588,026
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 784,301
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Other		
Gadsden Teen Clinic		$ 92,000
Direct Services Line 4 Expended Total		$ 2,464,327
Federal Total	$ 20,767,711	$ 19,837,392

IIB. Non-Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Direct Services	$ 600,000	$ 502,982
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 600,000	$ 502,982
2. Enabling Services	$ 151,135,749	$ 152,068,864
3. Public Health Services and Systems	$ 3,476,573	$ 2,640,476
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 71,402
Physician/Office Services		$ 429,230
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 2,350
Laboratory Services		$ 0
Direct Services Line 4 Expended Total		$ 502,982
Non-Federal Total	$ 155,212,322	$ 155,212,322

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

None

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: Florida

Total Births by Occurrence: 220,010 **Data Source Year: 2019**

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Valid Screen	(B) Aggregate Total Number of Out-of-Range Results	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	217,025 (98.6%)	1,373	419	419 (100.0%)

Program Name(s)				
3-Hydroxy-3-Methyglutaric Aciduria	3-Methylcrotonyl-Coa Carboxylase Deficiency	Argininosuccinic Aciduria	Biotinidase Deficiency	Carnitine Uptake Defect/Carnitine Transport Defect
Citrullinemia, Type I	Classic Galactosemia	Classic Phenylketonuria	Congenital Adrenal Hyperplasia	Critical Congenital Heart Disease
Cystic Fibrosis	Glutaric Acidemia Type I	Holocarboxylase Synthase Deficiency	Homocystinuria	Isovaleric Acidemia
Long-Chain L-3 Hydroxyacyl-Coa Dehydrogenase Deficiency	Maple Syrup Urine Disease	Medium-Chain Acyl-Coa Dehydrogenase Deficiency	Methylmalonic Acidemia (Cobalamin Disorders)	Methylmalonic Acidemia (Methylmalonyl-Coa Mutase)
Primary Congenital Hypothyroidism	Propionic Acidemia	S, ßeta-Thalassemia	S,C Disease	S,S Disease (Sickle Cell Anemia)
Severe Combined Immunodeficiences	ß-Ketothiolase Deficiency	Trifunctional Protein Deficiency	Tyrosinemia, Type I	Very Long-Chain Acyl-Coa Dehydrogenase Deficiency
X-Linked Adrenoleukodystrophy				

2. Other Newborn Screening Tests

Program Name	(A) Total Number Receiving at Least One Screen	(B) Total Number Presumptive Positive Screens	(C) Total Number Confirmed Cases	(D) Total Number Referred for Treatment
Hearing*	209,204 (95.1%)	9,453	253	250 (98.8%)

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

The Florida Newborn Screening process follows the child from the point of identification through confirmatory testing and diagnosis.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

1.	**Field Name:**	**Hearing* - Total Number Referred For Treatment**
	Fiscal Year:	**2020**
	Column Name:	**Other Newborn**

Field Note:
Three babies diagnosed in Florida were born to families with a history of a hearing difference that use ASL and declined a referral to Early Steps.

Data Alerts: None

Form 5
Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V

State: Florida

Annual Report Year 2020

Form 5a – Count of Individuals Served by Title V (Direct & Enabling Services Only)

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	124,814	94.8	1.3	3.9	0.0	0.0
2. Infants < 1 Year of Age	66,562	94.8	1.5	3.7	0.0	0.0
3. Children 1 through 21 Years of Age	148,052	95.3	0.9	3.8	0.0	0.0
3a. Children with Special Health Care Needs 0 through 21 years of age^	91,813	88.6	11.4	0.0	0.0	0.0
4. Others	0					
Total	339,428					

Form 5b – Total Percentage of Populations Served by Title V (Direct, Enabling, and Public Health Services and Systems)

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	220,002	Yes	220,002	100.0	220,002	124,814
2. Infants < 1 Year of Age	220,230	Yes	220,230	100.0	220,230	66,562
3. Children 1 through 21 Years of Age	4,982,448	Yes	4,982,448	64.0	3,188,767	148,052
3a. Children with Special Health Care Needs 0 through 21 years of age^	952,316	Yes	952,316	15.0	142,847	91,813
4. Others	16,273,826	Yes	16,273,826	0.0	0	0

^Represents a subset of all infants and children.

Form Notes for Form 5:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2020**
	Field Note: The pregnant women count is the count of women served in program components 25, 26, and 27 (Improved Pregnancy Outcome, Healthy Start Prenatal non-CHD, Healthy Start Prenatal CHD).	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2020**
	Field Note: The infant count is the count of infants (age=0) served in program components 29, 30, and 31 (Child Health, Healthy Start Child - non-County Health Department, and Healthy Start Child - CHD).	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2020**
	Field Note: The children age 1 to 22 is the count of children age 1 to 22 served in program component 29, 30, and 31 (Child Health, Healthy Start Child - non-CHD, and Healthy Start Child - CHD) during calendar year 2017. The total CSHCN is included in this rule based on how the TVIS calculates the total, with the row for CSHCN not calculated in the total. Actual total for Row 3 Children 1-22 years of age was 214,469 (not including CSHCN).	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2020**
	Field Note: The CSHCN count is the unduplicated count of clients served under Title V during the reporting period. Even if a client has moved between CMS T19 and T21 programs during the reporting period, we still count him/her once.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2020**
	Field Note: Florida does not collected data on others. There are no fiscal categories for others to generate a total to include on form 5- line 4, so we cannot establish a number for others. Those services are included in categories above.	

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women**
	Fiscal Year:	**2020**
	Field Note: Pregnant women percentage calculated on the number of pregnant women screened for Healthy Start. The prenatal screen is mandated to reach 100% of pregnant women. However, pregnant women can decline to be screened.	
2.	**Field Name:**	**InfantsLess Than One Year**
	Fiscal Year:	**2020**
	Field Note: Infant percentage calculated on the number of infants who received newborn screening.	
3.	**Field Name:**	**Children 1 Through 21 Years of Age**
	Fiscal Year:	**2020**
	Field Note: Children 1-22 percentage calculated on the number of children in public schools plus number served in 5a.	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2020**
	Field Note: CSHCN percentage calculated on the total count of clients in CMS T19 and T21 programs during the reporting period, not unduplicated if a client moved between the two programs.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2020**
	Field Note: Florida does not collect data on others. There are no fiscal categories for others to generate a total to include on form 5b-line 3a, so we cannot establish a number for others. Those services are included in categories above.	

Data Alerts: None

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Florida

Annual Report Year 2020

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non-Hispanic White	(C) Non-Hispanic Black or African American	(D) Hispanic	(E) Non-Hispanic American Indian or Native Alaskan	(F) Non-Hispanic Asian	(G) Non-Hispanic Native Hawaiian or Other Pacific Islander	(H) Non-Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	209,152	85,120	43,869	65,123	211	6,067	116	3,544	5,102
Title V Served	124,814	50,796	26,179	38,863	126	3,621	69	2,115	3,045
Eligible for Title XIX	118,349	48,166	24,823	36,850	119	3,433	66	2,005	2,887
2. Total Infants in State	220,010	90,997	46,316	67,681	236	6,963	160	3,832	3,825
Title V Served	66,562	27,530	14,013	20,476	71	2,107	49	1,159	1,157
Eligible for Title XIX	63,087	26,093	13,280	19,407	68	1,997	46	1,099	1,097

Form Notes for Form 6:

None

Field Level Notes for Form 6:

None

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Florida

A. State MCH Toll-Free Telephone Lines	2022 Application Year	2020 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 451-2229	(850) 451-2229
2. State MCH Toll-Free "Hotline" Name	Family Health Line	Family Health Line
3. Name of Contact Person for State MCH "Hotline"	Leilani Simmons	Leilani Simmons
4. Contact Person's Telephone Number	(850) 245-4103	(850) 245-4103
5. Number of Calls Received on the State MCH "Hotline"		2,576

B. Other Appropriate Methods	2022 Application Year	2020 Annual Report Year
1. Other Toll-Free "Hotline" Names		
2. Number of Calls on Other Toll-Free "Hotlines"		
3. State Title V Program Website Address		
4. Number of Hits to the State Title V Program Website		
5. State Title V Social Media Websites		
6. Number of Hits to the State Title V Program Social Media Websites		

Form Notes for Form 7:

None

Form 8
State MCH and CSHCN Directors Contact Information

State: Florida

1. Title V Maternal and Child Health (MCH) Director	
Name	Shay Chapman, BSN, MBA
Title	Deputy Division Director, Community Health Promotion
Address 1	4052 Bald Cypress Way, Bin A-13
Address 2	
City/State/Zip	Tallahassee / FL / 32399
Telephone	(850) 245-4464
Extension	
Email	Shay.Chapman@flhealth.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Jeffrey Brosco, MD, PHD
Title	Title V CSHCN Director
Address 1	4052 Bald Cypress Way, Bin A-13
Address 2	
City/State/Zip	Tallahassee / FL / 32399
Telephone	(850) 901-6303
Extension	
Email	Jeffrey.Brosco@flhealth.gov

3. State Family or Youth Leader (Optional)	
Name	Linda Starnes
Title	Statewide Family Leader
Address 1	4052 Bald Cypress Way, Bin A-13
Address 2	
City/State/Zip	Tallahassee / FL / 32399
Telephone	(407) 538-7180
Extension	
Email	Linda.Starnes@flhealth.gov

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: Florida

Application Year 2022

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Promote safe and healthy infant sleep behaviors and environments including improving support systems, and daily living conditions that make safe sleep practices challenging.	Continued
2.	Promote activities to improve the health of children and adolescents and promote participation in extracurricular and/or out-of- school activities in a safe and healthy environment.	Continued
3.	Promote tobacco cessation to reduce adverse birth outcomes and secondhand smoke exposure to children.	Continued
4.	Promote breastfeeding to ensure better health for infants and children and reduce low food security.	Continued
5.	Improve access to health care for women, specifically women who face significant barriers to better health, to improve preconception health.	Continued
6.	Increase access to medical homes and primary care for children with special health care needs.	Continued
7.	Increase access to behavioral health services	New
8.	Improve dental care access for children and pregnant women	Revised
9.	Address the social determinants of health that influence the relationship between health status and biology, individual behavior, health services, social factors, and policies.	New

Form Notes for Form 9:

None

Field Level Notes for Form 9:

Field Name:

Priority Need 5

Field Note:
Increase the percent of higher risk mothers and very low birth weight newborns that deliver at hospitals with a Level III+ Neonatal Intensive Care Unit (NICU).

Form 9 State Priorities – Needs Assessment Year – Application Year 2021

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Promote safe and healthy infant sleep behaviors and environments including improving support systems, and daily living conditions that make safe sleep practices challenging.	Continued
2.	Promote activities to improve the health of children and adolescents and promote participation in extracurricular and/or out-of- school activities in a safe and healthy environment.	Continued
3.	Promote tobacco cessation to reduce adverse birth outcomes and secondhand smoke exposure to children.	Continued
4.	Promote breastfeeding to ensure better health for infants and children and reduce low food security.	Continued
5.	Improve access to health care for women, specifically women who face significant barriers to better health, to improve preconception health.	Continued
6.	Increase access to medical homes and primary care for children with special health care needs.	Continued
7.	Improve health care transition for adolescents and young adults with special health care needs to all aspects of adult life.	Continued

Form Notes for Form 9:

None

Field Level Notes for Form 9:

Field Name:

Priority Need 5

Field Note:
Increase the percent of higher risk mothers and very low birth weight newborns that deliver at hospitals with a Level III+ Neonatal Intensive Care Unit (NICU).

Form 10
National Outcome Measures (NOMs)

State: Florida

Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.

None

NOM 1 - Percent of pregnant women who receive prenatal care beginning in the first trimester

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	72.5 %	0.1 %	150,552	207,577
2018	72.8 %	0.1 %	152,604	209,564
2017	73.7 %	0.1 %	154,802	210,027
2016	74.9 %	0.1 %	158,547	211,662
2015	75.7 %	0.1 %	161,407	213,229
2014	75.6 %	0.1 %	159,417	210,735
2013	73.2 %	0.1 %	152,189	207,988
2012	73.1 %	0.1 %	150,595	205,947
2011	73.8 %	0.1 %	150,478	203,797
2010	72.7 %	0.1 %	144,841	199,326
2009	71.7 %	0.1 %	149,827	209,106

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 1 - Notes:

None

Data Alerts: None

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	73.4	1.9	1,551	211,294
2017	73.0	1.9	1,561	213,722
2016	72.4	1.8	1,558	215,289
2015	77.7	2.2	1,230	158,310
2014	72.2	1.9	1,506	208,674
2013	70.3	1.9	1,442	205,083
2012	68.3	1.8	1,389	203,334
2011	68.3	1.8	1,392	203,894
2010	69.7	1.9	1,429	205,167
2009	68.6	1.8	1,443	210,214
2008	65.7	1.7	1,449	220,643

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 2 - Notes:

None

Data Alerts: None

NOM 3 - Maternal mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015_2019	18.1	1.3	202	1,114,465
2014_2018	16.7	1.2	186	1,114,454

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 3 - Notes:

None

Data Alerts: None

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	8.7 %	0.1 %	19,231	219,922
2018	8.7 %	0.1 %	19,217	221,471
2017	8.8 %	0.1 %	19,653	223,561
2016	8.7 %	0.1 %	19,589	224,935
2015	8.6 %	0.1 %	19,306	224,193
2014	8.7 %	0.1 %	19,065	219,927
2013	8.5 %	0.1 %	18,346	215,338
2012	8.6 %	0.1 %	18,260	213,076
2011	8.7 %	0.1 %	18,527	213,363
2010	8.7 %	0.1 %	18,681	214,525
2009	8.7 %	0.1 %	19,247	221,319

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 4 - Notes:

None

Data Alerts: None

NOM 5 - Percent of preterm births (<37 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	10.6 %	0.1 %	23,361	219,916
2018	10.3 %	0.1 %	22,701	221,437
2017	10.2 %	0.1 %	22,851	223,511
2016	10.1 %	0.1 %	22,822	224,921
2015	10.0 %	0.1 %	22,407	224,173
2014	9.9 %	0.1 %	21,846	219,909
2013	10.0 %	0.1 %	21,594	215,168
2012	10.2 %	0.1 %	21,810	212,925
2011	10.3 %	0.1 %	22,018	213,054
2010	10.5 %	0.1 %	22,436	214,301
2009	10.6 %	0.1 %	23,344	221,161

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 5 - Notes:

None

Data Alerts: None

NOM 6 - Percent of early term births (37, 38 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	28.0 %	0.1 %	61,531	219,916
2018	27.5 %	0.1 %	60,947	221,437
2017	27.0 %	0.1 %	60,295	223,511
2016	26.3 %	0.1 %	59,240	224,921
2015	25.7 %	0.1 %	57,676	224,173
2014	25.7 %	0.1 %	56,543	219,909
2013	26.4 %	0.1 %	56,704	215,168
2012	27.1 %	0.1 %	57,640	212,925
2011	27.8 %	0.1 %	59,291	213,054
2010	30.2 %	0.1 %	64,627	214,301
2009	32.1 %	0.1 %	70,945	221,161

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 6 - Notes:

None

Data Alerts: None

NOM 7 - Percent of non-medically indicated early elective deliveries

Data Source: CMS Hospital Compare

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019/Q1-2019/Q4	2.0 %			
2018/Q4-2019/Q3	2.0 %			
2018/Q3-2019/Q2	1.0 %			
2018/Q2-2019/Q1	1.0 %			
2018/Q1-2018/Q4	1.0 %			
2017/Q4-2018/Q3	1.0 %			
2017/Q3-2018/Q2	1.0 %			
2017/Q2-2018/Q1	2.0 %			
2017/Q1-2017/Q4	2.0 %			
2016/Q4-2017/Q3	2.0 %			
2016/Q3-2017/Q2	2.0 %			
2016/Q2-2017/Q1	2.0 %			
2016/Q1-2016/Q4	2.0 %			
2015/Q4-2016/Q3	2.0 %			
2015/Q3-2016/Q2	2.0 %			
2015/Q2-2016/Q1	2.0 %			
2015/Q1-2015/Q4	2.0 %			
2014/Q4-2015/Q3	2.0 %			
2014/Q3-2015/Q2	3.0 %			
2014/Q2-2015/Q1	3.0 %			
2014/Q1-2014/Q4	3.0 %			
2013/Q4-2014/Q3	4.0 %			
2013/Q3-2014/Q2	5.0 %			
2013/Q2-2014/Q1	6.0 %			

Legends:

NOM 7 - Notes:

None

Data Alerts: None

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	6.1	0.2	1,362	222,190
2017	6.5	0.2	1,453	224,372
2016	6.5	0.2	1,475	225,728
2015	6.6	0.2	1,486	224,944
2014	6.5	0.2	1,425	220,685
2013	6.6	0.2	1,417	216,119
2012	6.6	0.2	1,419	213,877
2011	6.9	0.2	1,473	214,141
2010	6.8	0.2	1,459	215,306
2009	6.8	0.2	1,520	222,137

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 8 - Notes:

None

Data Alerts: None

NOM 9.1 - Infant mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	6.0	0.2	1,339	221,542
2017	6.1	0.2	1,364	223,630
2016	6.1	0.2	1,382	225,022
2015	6.2	0.2	1,399	224,269
2014	6.1	0.2	1,344	219,991
2013	6.1	0.2	1,322	215,407
2012	6.1	0.2	1,306	213,148
2011	6.5	0.2	1,379	213,414
2010	6.5	0.2	1,397	214,590
2009	6.9	0.2	1,527	221,394

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.1 - Notes:

None

Data Alerts: None

NOM 9.2 - Neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	4.1	0.1	898	221,542
2017	4.1	0.1	907	223,630
2016	4.2	0.1	936	225,022
2015	4.4	0.1	986	224,269
2014	4.2	0.1	913	219,991
2013	4.0	0.1	868	215,407
2012	4.0	0.1	847	213,148
2011	4.3	0.1	920	213,414
2010	4.4	0.1	937	214,590
2009	4.5	0.1	994	221,394

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.2 - Notes:

None

Data Alerts: None

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2018	2.0	0.1	441	221,542
2017	2.0	0.1	457	223,630
2016	2.0	0.1	446	225,022
2015	1.8	0.1	413	224,269
2014	2.0	0.1	431	219,991
2013	2.1	0.1	454	215,407
2012	2.2	0.1	459	213,148
2011	2.2	0.1	459	213,414
2010	2.1	0.1	460	214,590
2009	2.4	0.1	533	221,394

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.3 - Notes:

None

Data Alerts: None

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	218.9	10.0	485	221,542
2017	211.5	9.7	473	223,630
2016	225.8	10.0	508	225,022
2015	243.0	10.4	545	224,269
2014	234.6	10.3	516	219,991
2013	227.5	10.3	490	215,407
2012	229.9	10.4	490	213,148
2011	245.5	10.7	524	213,414
2010	251.2	10.8	539	214,590
2009	257.9	10.8	571	221,394

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.4 - Notes:

None

Data Alerts: None

NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	87.6	6.3	194	221,542
2017	101.5	6.7	227	223,630
2016	85.3	6.2	192	225,022
2015	81.2	6.0	182	224,269
2014	87.7	6.3	193	219,991
2013	93.8	6.6	202	215,407
2012	83.0	6.2	177	213,148
2011	82.0	6.2	175	213,414
2010	85.3	6.3	183	214,590
2009	86.3	6.3	191	221,394

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.5 - Notes:

None

Data Alerts: None

NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy

Federally available Data (FAD) for this measure is not available/reportable.

NOM 10 - Notes:

This data is currently not available. Florida PRAMS collects data on alcohol use three months before pregnancy and the past two years.

Data Alerts:

1.	Data has not been entered for NOM 10. This outcome measure is linked to the selected NPM 1,. Please add a field level note to explain when and how data will be available for tracking this outcome measure.

NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	6.9	0.2	1,464	213,243
2017	7.2	0.2	1,558	215,435
2016	7.3	0.2	1,592	217,561
2015	7.2	0.2	1,156	160,465
2014	6.8	0.2	1,433	210,719
2013	6.4	0.2	1,319	207,144
2012	6.0	0.2	1,240	205,662
2011	6.0	0.2	1,229	206,301
2010	4.9	0.2	1,024	208,052
2009	3.5	0.1	740	213,310
2008	2.3	0.1	518	223,776

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 11 - Notes:

None

Data Alerts: None

NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 12 - Notes:

None

Data Alerts: None

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 13 - Notes:

None

Data Alerts: None

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	12.8 %	1.5 %	513,887	3,999,776
2017_2018	12.5 %	1.6 %	487,771	3,895,296
2016_2017	11.8 %	1.5 %	451,376	3,817,682
2016	13.5 %	1.8 %	516,250	3,829,255

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 14 - Notes:

None

Data Alerts: None

NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2019	17.4	0.9	363	2,084,629
2018	18.9	1.0	393	2,078,730
2017	20.2	1.0	416	2,063,833
2016	19.7	1.0	402	2,044,233
2015	20.3	1.0	410	2,015,646
2014	20.1	1.0	401	1,995,207
2013	19.5	1.0	385	1,975,876
2012	19.2	1.0	375	1,954,997
2011	20.7	1.0	402	1,941,084
2010	20.9	1.0	407	1,945,037
2009	21.3	1.1	412	1,936,378

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 15 - Notes:

None

Data Alerts: None

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	31.6	1.1	760	2,408,483
2018	30.7	1.1	741	2,412,669
2017	34.8	1.2	831	2,385,070
2016	35.6	1.2	834	2,343,610
2015	32.4	1.2	755	2,330,369
2014	31.6	1.2	730	2,309,604
2013	29.3	1.1	676	2,303,428
2012	31.8	1.2	734	2,309,847
2011	33.0	1.2	768	2,327,390
2010	32.2	1.2	759	2,359,229
2009	35.5	1.2	841	2,365,899

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.1 - Notes:

None

Data Alerts: None

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2019	14.3	0.6	518	3,612,598
2016_2018	15.3	0.7	549	3,599,580
2015_2017	15.4	0.7	551	3,576,111
2014_2016	14.7	0.6	522	3,543,901
2013_2015	13.2	0.6	465	3,525,120
2012_2014	12.6	0.6	445	3,518,703
2011_2013	13.0	0.6	459	3,542,990
2010_2012	14.1	0.6	509	3,600,735
2009_2011	14.7	0.6	539	3,661,955
2008_2010	16.8	0.7	624	3,707,519
2007_2009	20.1	0.7	748	3,712,629

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.2 - Notes:

None

Data Alerts: None

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2019	9.2	0.5	331	3,612,598
2016_2018	9.0	0.5	323	3,599,580
2015_2017	8.4	0.5	301	3,576,111
2014_2016	7.9	0.5	280	3,543,901
2013_2015	7.4	0.5	262	3,525,120
2012_2014	7.6	0.5	269	3,518,703
2011_2013	7.5	0.5	264	3,542,990
2010_2012	6.7	0.4	242	3,600,735
2009_2011	6.0	0.4	221	3,661,955
2008_2010	5.6	0.4	209	3,707,519
2007_2009	6.0	0.4	224	3,712,629

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.3 - Notes:

None

Data Alerts: None

NOM 17.1 - Percent of children with special health care needs (CSHCN), ages 0 through 17

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	18.3 %	1.4 %	771,337	4,206,869
2017_2018	18.9 %	1.7 %	787,817	4,164,368
2016_2017	20.9 %	1.7 %	860,723	4,111,292
2016	21.8 %	1.8 %	891,111	4,087,976

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.1 - Notes:

None

Data Alerts: None

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	7.7 %	1.7 %	59,681	771,337
2017_2018	7.5 %	2.0 %	58,905	787,817
2016_2017	8.9 %	1.9 %	76,934	860,723
2016	10.0 %	2.2 %	89,423	891,111

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	2.1 %	0.5 %	73,636	3,570,582
2017_2018	1.2 %	0.4 %	42,945	3,506,346
2016_2017	2.9 %	0.6 %	98,023	3,402,055
2016	4.5 %	1.1 %	152,296	3,378,120

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	8.4 %	1.0 %	296,748	3,548,639
2017_2018	9.8 %	1.4 %	341,961	3,472,387
2016_2017	9.5 %	1.4 %	320,691	3,378,156
2016	8.2 %	1.2 %	275,127	3,347,819

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	53.0 %	5.7 %	225,277	425,444
2017_2018	48.2 %	6.5 %	206,702	428,700
2016_2017	46.5 %	6.0 %	213,092	458,660
2016	49.1 %	6.7 %	215,430	439,176

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts: None

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	91.3 %	1.1 %	3,829,480	4,192,302
2017_2018	90.8 %	1.4 %	3,762,232	4,143,910
2016_2017	87.8 %	1.5 %	3,597,248	4,098,477
2016	86.7 %	1.7 %	3,541,192	4,082,443

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	13.3 %	0.1 %	23,956	179,667
2016	12.7 %	0.1 %	24,635	193,749
2014	12.7 %	0.1 %	23,253	182,567
2012	13.7 %	0.1 %	23,575	171,832
2010	14.6 %	0.1 %	28,384	194,924
2008	15.0 %	0.1 %	22,538	150,046

Legends:

Indicator has a denominator <50 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	14.0 %	0.7 %	102,133	731,810
2017	10.9 %	0.7 %	71,768	655,860
2015	12.3 %	0.6 %	84,589	688,764
2013	11.6 %	0.6 %	83,998	724,609
2011	11.5 %	0.6 %	78,165	678,193
2009	10.3 %	0.5 %	67,684	657,645
2007	11.2 %	0.7 %	76,011	681,417
2005	10.8 %	0.5 %	75,120	694,616

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	17.8 %	2.1 %	328,817	1,848,950
2017_2018	17.8 %	2.6 %	318,848	1,786,940
2016_2017	16.9 %	2.5 %	299,302	1,775,792
2016	17.9 %	2.7 %	302,065	1,690,458

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children, ages 0 through 17, without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	7.2 %	0.2 %	306,629	4,230,542
2018	7.4 %	0.2 %	311,663	4,224,475
2017	6.9 %	0.2 %	291,327	4,198,690
2016	6.2 %	0.2 %	258,020	4,142,576
2015	6.9 %	0.2 %	281,867	4,102,077
2014	9.2 %	0.3 %	372,586	4,052,007
2013	11.0 %	0.3 %	443,880	4,025,110
2012	10.8 %	0.3 %	431,221	3,997,922
2011	11.9 %	0.3 %	474,740	3,992,737
2010	12.8 %	0.3 %	513,357	3,999,244
2009	14.8 %	0.3 %	600,227	4,056,356

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 21 - Notes:

None

Data Alerts: None

NOM 22.1 - Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	71.4 %	3.9 %	165,000	231,000
2015	69.6 %	3.9 %	163,000	234,000
2014	68.8 %	4.1 %	158,000	230,000
2013	63.5 %	4.0 %	142,000	224,000
2012	67.8 %	4.2 %	150,000	221,000
2011	67.2 %	4.7 %	147,000	219,000

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths >20 or that are inestimable might not be reliable

NOM 22.1 - Notes:

None

Data Alerts: None

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS) – Flu

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	55.8 %	1.6 %	2,086,606	3,739,437
2018_2019	54.6 %	1.8 %	2,155,885	3,952,127
2017_2018	46.1 %	1.7 %	1,766,170	3,833,617
2016_2017	56.7 %	1.8 %	2,148,061	3,787,799
2015_2016	47.9 %	1.8 %	1,777,685	3,712,793
2014_2015	48.0 %	1.9 %	1,780,234	3,712,688
2013_2014	50.3 %	1.9 %	1,867,932	3,714,239
2012_2013	46.9 %	2.6 %	1,722,142	3,672,407
2011_2012	43.9 %	3.3 %	1,632,951	3,716,498
2010_2011	38.9 %	1.9 %	1,442,929	3,709,328
2009_2010	37.9 %	2.4 %	1,366,413	3,605,312

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or because the relative standard error is >0.3.

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.2 - Notes:

None

Data Alerts: None

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	67.9 %	4.0 %	822,184	1,210,865
2018	64.1 %	3.4 %	766,311	1,194,804
2017	59.8 %	3.3 %	705,301	1,180,162
2016	55.9 %	3.4 %	661,631	1,182,903
2015	53.7 %	3.6 %	630,533	1,173,544

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.3 - Notes:

None

Data Alerts: None

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	95.6 %	1.5 %	1,157,570	1,210,865
2018	90.1 %	2.0 %	1,076,282	1,194,804
2017	91.1 %	1.8 %	1,075,554	1,180,162
2016	89.7 %	2.2 %	1,061,480	1,182,903
2015	87.3 %	2.5 %	1,024,631	1,173,544
2014	90.7 %	2.1 %	1,061,277	1,169,950
2013	84.8 %	2.8 %	990,810	1,168,561
2012	86.8 %	2.6 %	1,006,684	1,160,414
2011	77.5 %	2.7 %	899,634	1,160,986
2010	61.9 %	3.3 %	688,244	1,111,347
2009	47.2 %	3.1 %	536,871	1,137,222

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.4 - Notes:

None

Data Alerts: None

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	82.9 %	3.2 %	1,003,391	1,210,865
2018	76.3 %	3.0 %	911,070	1,194,804
2017	80.2 %	2.7 %	946,112	1,180,162
2016	76.3 %	2.9 %	902,900	1,182,903
2015	70.4 %	3.3 %	825,716	1,173,544
2014	72.2 %	3.4 %	844,322	1,169,950
2013	72.3 %	3.3 %	844,690	1,168,561
2012	68.6 %	3.5 %	796,377	1,160,414
2011	61.2 %	3.1 %	710,999	1,160,986
2010	55.1 %	3.4 %	612,809	1,111,347
2009	52.7 %	3.1 %	599,159	1,137,222

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.5 - Notes:

None

Data Alerts: None

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	16.2	0.2	9,541	587,772
2018	16.7	0.2	9,829	588,946
2017	18.2	0.2	10,708	587,833
2016	19.3	0.2	11,195	579,919
2015	20.8	0.2	11,957	574,463
2014	22.5	0.2	12,816	568,741
2013	24.6	0.2	13,962	568,335
2012	28.1	0.2	15,952	568,628
2011	29.6	0.2	17,125	578,320
2010	32.3	0.2	19,127	593,034
2009	36.6	0.3	22,021	601,533

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 23 - Notes:

None

Data Alerts: None

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	13.0 %	1.3 %	26,830	206,294

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 24 - Notes:

None

Data Alerts: None

NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	3.6 %	0.6 %	152,408	4,187,864
2017_2018	3.9 %	1.0 %	160,483	4,132,738
2016_2017	4.8 %	1.1 %	197,693	4,077,844
2016	5.0 %	1.2 %	201,082	4,062,104

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 25 - Notes:

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)

State: Florida

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective					72
Annual Indicator				76.4	72.2
Numerator				2,630,508	2,531,649
Denominator				3,443,178	3,508,023
Data Source				BRFSS	BRFSS
Data Source Year				2018	2019

Previous NPM-1 BRFSS data for survey years 2015, 2016 and 2017 that was pre-populated under the 2016, 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable with 2018 survey data.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	73.0	74.0	75.0	76.0	77.0	78.0

Field Level Notes for Form 10 NPMs:

None

NPM 3 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	78.9	78.1
Numerator	2,737	2,492
Denominator	3,469	3,191
Data Source	Florida CHARTS	Florida CHARTS
Data Source Year	2019	2020
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	79.4	80.0	80.5	81.0	81.6	82.1

Field Level Notes for Form 10 NPMs:

None

NPM 4A - Percent of infants who are ever breastfed

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	81.3	82.3	83.2	84	84.7
Annual Indicator	81.1	76.1	82.6	79.2	75.6
Numerator	171,099	155,283	190,605	168,560	157,351
Denominator	210,888	203,992	230,680	212,751	208,001
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016	2017

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	85.3	85.8	86.2	87.1	87.8	88.4

Field Level Notes for Form 10 NPMs:

None

NPM 4B - Percent of infants breastfed exclusively through 6 months

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	27.7	29.4	31.1	32.8	34.5
Annual Indicator	18.4	24.3	21.3	23.4	19.9
Numerator	37,940	49,156	47,798	48,426	39,516
Denominator	206,047	201,974	224,023	206,578	198,423
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016	2017

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	23.4	26.9	30.4	33.9	37.4	40.4

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**
	Field Note: Annual objectives were updated to be inline with annual indicator for 2020.	
2.	**Field Name:**	**2022**
	Column Name:	**Annual Objective**
	Field Note: Annual objectives were updated to be inline with annual indicator for 2020.	
3.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**
	Field Note: Annual objectives were updated to be inline with annual indicator for 2020.	
4.	**Field Name:**	**2024**
	Column Name:	**Annual Objective**
	Field Note: Annual objectives were updated to be inline with annual indicator for 2020.	
5.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**
	Field Note: Annual objectives were updated to be inline with annual indicator for 2020.	
6.	**Field Name:**	**2026**
	Column Name:	**Annual Objective**
	Field Note: Annual objectives were updated to be inline with annual indicator for 2020.	

NPM 5A - Percent of infants placed to sleep on their backs

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2020
Annual Objective	76.3
Annual Indicator	74.3
Numerator	153,404
Denominator	206,486
Data Source	PRAMS
Data Source Year	2019

State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	78.3	73.3	74.5	75.4	76.3
Annual Indicator	69.5	74	74	72.1	74.3
Numerator					
Denominator					
Data Source	FL PRAMS Data	FL PRAMS Data	FL PRAMS	FL PRAMS	FL PRAMS
Data Source Year	2014	2015	2015	2018	2019
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	77.1	77.9	78.9	79.8	80.9	81.7

Field Level Notes for Form 10 NPMs:

None

NPM 5B - Percent of infants placed to sleep on a separate approved sleep surface

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2020
Annual Objective	83
Annual Indicator	36.0
Numerator	71,406
Denominator	198,188
Data Source	PRAMS
Data Source Year	2019

State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			82	83
Annual Indicator	78	35.4	35.3	35.3
Numerator				
Denominator				
Data Source	FL PRAMS Data	FL PRAMS Data	FL PRAMS	FL PRAMS
Data Source Year	2015	2018	2018	2019
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	36.3	36.8	37.3	37.8	38.3	38.7

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
The 2018 data was updated with actual 2018 PRAMS data. However, due to changes in question wording, assessing trends in sleep behaviors between phase 7 and 8 is limited, with the exception of infant sleep position.

We used the CDC recommended code to calculated the data as follows:
Percent of infants placed to sleep on a separate approved sleep surface (“always or often” versus “sometimes, rarely, or never”)
if (sleepown in (1,2)) and (slp_crb8 =2) and (slp_mat8 =1 and slp_chr =1 and slp_swg =1) then approved_surface=2; *yes;
else if (sleepown in (3,4,5)) or (slp_crb8 =1) or (slp_mat8 =2 or slp_chr =2 or slp_swg =2) then approved_surface=1; *no;
if (sleepown <= 0) or (slp_crb8<=0) or (slp_mat8<=0 or slp_chr<=0 or slp_swg<=0) then approved_surface=.; *missing;
*Defined as a composite of five items indicating how the infant usually slept in the past 2 weeks: 1) alone in their own crib or bed (always/often versus sometimes/rarely/never); 2) in a crib, bassinet, or pack and play; 3) not in a standard bed; 4) not in a couch or armchair; 5) not in car seat or swing.

2.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
The 2018 data was updated with actual 2018 PRAMS data. However, due to changes in question wording, assessing trends in sleep behaviors between phase 7 and 8 is limited, with the exception of infant sleep position.

We used the CDC recommended code to calculated the data as follows:
Percent of infants placed to sleep on a separate approved sleep surface (“always or often” versus “sometimes, rarely, or never”)
if (sleepown in (1,2)) and (slp_crb8 =2) and (slp_mat8 =1 and slp_chr =1 and slp_swg =1) then approved_surface=2; *yes;
else if (sleepown in (3,4,5)) or (slp_crb8 =1) or (slp_mat8 =2 or slp_chr =2 or slp_swg =2) then approved_surface=1; *no;
if (sleepown <= 0) or (slp_crb8<=0) or (slp_mat8<=0 or slp_chr<=0 or slp_swg<=0) then approved_surface=.; *missing;
*Defined as a composite of five items indicating how the infant usually slept in the past 2 weeks: 1) alone in their own crib or bed (always/often versus sometimes/rarely/never); 2) in a crib, bassinet, or pack and play; 3) not in a standard bed; 4) not in a couch or armchair; 5) not in car seat or swing.

3.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
FL PRAMS 2020 data is not available.

4.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**

	Field Note: Due to changes in question wording, assessing trends in sleep behaviors between phase 7 and 8 is limited, with the exception of infant sleep position. For this reason, the annual objectives were updated to be inline with the updated annual indicator.	
5.	**Field Name:**	**2022**
	Column Name:	**Annual Objective**
	Field Note: Due to changes in question wording, assessing trends in sleep behaviors between phase 7 and 8 is limited, with the exception of infant sleep position. For this reason, the annual objectives were updated to be inline with the updated annual indicator.	
6.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**
	Field Note: Due to changes in question wording, assessing trends in sleep behaviors between phase 7 and 8 is limited, with the exception of infant sleep position. For this reason, the annual objectives were updated to be inline with the updated annual indicator.	
7.	**Field Name:**	**2024**
	Column Name:	**Annual Objective**
	Field Note: Due to changes in question wording, assessing trends in sleep behaviors between phase 7 and 8 is limited, with the exception of infant sleep position. For this reason, the annual objectives were updated to be inline with the updated annual indicator.	
8.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**
	Field Note: Due to changes in question wording, assessing trends in sleep behaviors between phase 7 and 8 is limited, with the exception of infant sleep position. For this reason, the annual objectives were updated to be inline with the updated annual indicator.	
9.	**Field Name:**	**2026**
	Column Name:	**Annual Objective**
	Field Note: Due to changes in question wording, assessing trends in sleep behaviors between phase 7 and 8 is limited, with the exception of infant sleep position. For this reason, the annual objectives were updated to be inline with the updated annual indicator.	

NPM 5C - Percent of infants placed to sleep without soft objects or loose bedding

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2020
Annual Objective	63
Annual Indicator	48.8
Numerator	96,651
Denominator	197,982
Data Source	PRAMS
Data Source Year	2019

State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			62	63
Annual Indicator	60	42.3	48.2	48.2
Numerator				
Denominator				
Data Source	FL PRAMS Data	FL PRAMS	FL PRAMS	FL PRAMS
Data Source Year	2015	2018	2018	2019
Provisional or Final ?	Provisional	Final	Final	Final

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	50.2	51.2	52.2	53.2	54.2	56.4

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

	Field Note: FL PRAMS data for this measure will be available late in 2018 or early 2019. Data provided is an estimate based on CDC data from 2014 that 55 percent of babies nationwide were sleeping with soft objects or loose bedding. Indicator and objectives will be updated when FL PRAMS data becomes available.	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: The 2018 data was updated with actual 2018 PRAMS data. However, due to changes in question wording, assessing trends in sleep behaviors between phase 7 and 8 is limited, with the exception of infant sleep position.	
3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: The 2019 data was updated with actual 2018 PRAMS data. However, due to changes in question wording, assessing trends in sleep behaviors between phase 7 and 8 is limited, with the exception of infant sleep position.	
4.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: FL PRAMS 2020 data is not available.	
5.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**
	Field Note: Due to changes in question wording, assessing trends in sleep behaviors between phase 7 and 8 is limited, with the exception of infant sleep position. For this reason, the annual objectives were updated to be inline with the updated annual indicator.	
6.	**Field Name:**	**2022**
	Column Name:	**Annual Objective**
	Field Note: Due to changes in question wording, assessing trends in sleep behaviors between phase 7 and 8 is limited, with the exception of infant sleep position. For this reason, the annual objectives were updated to be inline with the updated annual indicator.	
7.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**
	Field Note: Due to changes in question wording, assessing trends in sleep behaviors between phase 7 and 8 is limited, with the exception of infant sleep position. For this reason, the annual objectives were updated to be inline with the updated annual indicator.	

8.	**Field Name:**	**2024**
	Column Name:	**Annual Objective**
	Field Note: Due to changes in question wording, assessing trends in sleep behaviors between phase 7 and 8 is limited, with the exception of infant sleep position. For this reason, the annual objectives were updated to be inline with the updated annual indicator.	
9.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**
	Field Note: Due to changes in question wording, assessing trends in sleep behaviors between phase 7 and 8 is limited, with the exception of infant sleep position. For this reason, the annual objectives were updated to be inline with the updated annual indicator.	
10.	**Field Name:**	**2026**
	Column Name:	**Annual Objective**
	Field Note: Due to changes in question wording, assessing trends in sleep behaviors between phase 7 and 8 is limited, with the exception of infant sleep position. For this reason, the annual objectives were updated to be inline with the updated annual indicator.	

NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CHILD					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			33.5	34	34.5
Annual Indicator		32.5	29.4	25.8	26.3
Numerator		428,914	394,477	364,148	361,483
Denominator		1,321,058	1,341,890	1,409,470	1,375,329
Data Source		NSCH-CHILD	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	35.0	35.5	36.0	36.5	37.0	37.5

Field Level Notes for Form 10 NPMs:

None

NPM 8.2 - Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day

Federally Available Data		
Data Source: Youth Risk Behavior Surveillance System (YRBSS)		
	2019	**2020**
Annual Objective		
Annual Indicator	22.8	22.7
Numerator	181,534	185,277
Denominator	796,158	816,019
Data Source	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT
Data Source Year	2017	2019

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - ADOLESCENT		
	2019	**2020**
Annual Objective		
Annual Indicator	19.5	19.5
Numerator	290,239	280,894
Denominator	1,491,681	1,441,461
Data Source	NSCH-ADOLESCENT	NSCH-ADOLESCENT
Data Source Year	2017_2018	2018_2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	23.0	23.8	24.0	25.8	26.0	26.9

Field Level Notes for Form 10 NPMs:

None

NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Federally Available Data					
Data Source: Youth Risk Behavior Surveillance System (YRBSS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	20.2	19	18.7	18.4	18.1
Annual Indicator	19.5	19.5	18.9	18.9	18.8
Numerator	150,914	150,914	156,700	156,700	159,632
Denominator	772,407	772,407	827,044	827,044	847,255
Data Source	YRBSS	YRBSS	YRBSS	YRBSS	YRBSS
Data Source Year	2015	2015	2017	2017	2019

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - Perpetration				
	2017	**2018**	**2019**	**2020**
Annual Objective			18.4	18.1
Annual Indicator			6.9	9.7
Numerator			98,203	140,699
Denominator			1,426,809	1,444,881
Data Source			NSCHP	NSCHP
Data Source Year			2018	2018_2019

Previous NPM-9 NSCH data for survey years 2016 and 2017 that was pre-populated under the 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable to 2018 survey data given major wording and response option changes.

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - Victimization				
	2017	**2018**	**2019**	**2020**
Annual Objective			18.4	18.1
Annual Indicator			26.8	31.3
Numerator			383,474	452,299
Denominator			1,429,420	1,446,186
Data Source			NSCHV	NSCHV
Data Source Year			2018	2018_2019

Previous NPM-9 NSCH data for survey years 2016 and 2017 that was pre-populated under the 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable to 2018 survey data given major wording and response option changes.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	17.8	17.5	17.2	16.9	16.5	16.2

Field Level Notes for Form 10 NPMs:

None

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			46	48	50
Annual Indicator		33.5	30.8	30.3	34.1
Numerator		298,857	264,895	238,785	263,392
Denominator		891,111	860,723	787,817	771,337
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	34.5	35.0	35.5	40.0	40.5	41.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**
	Field Note: Annual Objective was updated to be more inline with the annual indicator.	
2.	**Field Name:**	**2022**
	Column Name:	**Annual Objective**
	Field Note: Annual Objective was updated to be more inline with the annual indicator.	
3.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**
	Field Note: Annual Objective was updated to be more inline with the annual indicator.	
4.	**Field Name:**	**2024**
	Column Name:	**Annual Objective**
	Field Note: Annual Objective was updated to be more inline with the annual indicator.	
5.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**
	Field Note: Annual Objective was updated to be more inline with the annual indicator.	
6.	**Field Name:**	**2026**
	Column Name:	**Annual Objective**
	Field Note: Annual Objective was updated to be more inline with the annual indicator.	

NPM 14.1 - Percent of women who smoke during pregnancy

Federally Available Data					
Data Source: National Vital Statistics System (NVSS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	6.5	6.4	6.3	6.2	6.1
Annual Indicator	5.8	5.1	4.8	4.5	4.1
Numerator	12,970	11,454	10,639	9,836	9,011
Denominator	223,231	224,109	221,925	220,538	219,141
Data Source	NVSS	NVSS	NVSS	NVSS	NVSS
Data Source Year	2015	2016	2017	2018	2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	4.0	3.9	3.8	3.7	3.6	2.7

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**
	Field Note: 2020 Annual indicator below 2020 annual objective. Annual objectives were updated to be inline with annual indicator.	
2.	**Field Name:**	**2022**
	Column Name:	**Annual Objective**
	Field Note: 2020 Annual indicator below 2020 annual objective. Annual objectives were updated to be inline with annual indicator.	
3.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**
	Field Note: 2020 Annual indicator below 2020 annual objective. Annual objectives were updated to be inline with annual indicator.	
4.	**Field Name:**	**2024**
	Column Name:	**Annual Objective**
	Field Note: 2020 Annual indicator below 2020 annual objective. Annual objectives were updated to be inline with annual indicator.	
5.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**
	Field Note: 2020 Annual indicator below 2020 annual objective. Annual objectives were updated to be inline with annual indicator.	
6.	**Field Name:**	**2026**
	Column Name:	**Annual Objective**
	Field Note: 2020 Annual indicator below 2020 annual objective. Annual objectives were updated to be inline with annual indicator.	

Form 10
National Performance Measures (NPMs) (2016-2020 Needs Assessment Cycle)

State: Florida

2016-2020: NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			10	12	14
Annual Indicator		7.5	5.9	6.4	16.8
Numerator		27,551	25,281	24,937	52,610
Denominator		368,685	426,713	387,391	313,204
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Field Level Notes for Form 10 NPMs:

None

Form 10
State Performance Measures (SPMs)

State: Florida

SPM 1 - The percentage of children that need mental health services that actually receive mental health services.

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		58	50	51	52
Annual Indicator	57.7	49.1	46.5	48.2	52.9
Numerator				99,630	225,227
Denominator				206,702	425,445
Data Source	National Survey of Children's Health	National Survey of Children's Health	National Survey of Children's Health	National Survey of Children's Health	National Survey of Children's Health
Data Source Year	2011-2012	2016	2017	2018	2018_2019
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	53.0	54.0	55.0	56.0	57.0	58.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
The survey methods changed from the 2011/12 survey when the 2016 indicator was determined and the 2016 survey when the 2017 indicator was determined. The apparent drop in percentage is due to the change in methodology rather than less children being served. Objectives were adjusted to reflect new data.

SPM 2 - The percentage of low-income children under age 21 who access dental care.

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		37.4	38.9	40.4	41.9
Annual Indicator	35.9	37.4	38.5	48.7	31.9
Numerator	986,425	1,037,798	1,045,121	755,818	842,727
Denominator	2,745,598	2,774,485	2,716,229	1,551,734	2,639,833
Data Source	Florida Agency for Health Care Administration	Florida Agency for Health Care Administration	Florida Agency for Health Care Administration	Florida Agency for Health Care Administration	Florida Agency for Health Care Administration
Data Source Year	2016	2017	2018	2017/2018	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	43.4	44.9	46.4	47.9	49.4	50.9

Field Level Notes for Form 10 SPMs:

None

SPM 3 - The percentage of parents who read to their young child age 0-5 years

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		45.1	34.7	35.2	35.7
Annual Indicator	42.6	34.2	32.9	32.1	27.4
Numerator	545,146	435,455	396,388	384,878	369,850
Denominator	1,279,782	1,273,260	1,204,876	1,198,761	1,347,822
Data Source	2011-12 National Survey of Children's Health	2016 National Survey of Child Health	2016 National Survey of Child Health	2017-18 National Survey of Child Health	2018-19 National Survey of Child Health
Data Source Year	2011-2012	2016	2016-2017	2017-2018	2018-2019
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	36.2	36.7	37.2	37.7	38.2	38.7

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
The survey methods changed from the 2011/12 survey when the 2016 indicator was determined and the 2016 survey when the 2017 indicator was determined. The apparent drop in percentage is due to the change in methodology rather than less children being read to. Objectives were adjusted to reflect new data.

Form 10
State Performance Measures (SPMs) (2016-2020 Needs Assessment Cycle)

2016-2020: SPM 4 - The percentage of individuals who received workforce development that reported improved public health competency and capacity.

Measure Status:			**Active**	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			75	89
Annual Indicator			89.3	95.7
Numerator			25	22
Denominator			28	23
Data Source			CMS Internal Survey	CMS Internal Survey
Data Source Year			2020	2020
Provisional or Final ?			Final	Final

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
Numerator was 25.5, unable to enter decimal. Actual percentage was 91%.

Form 10
State Outcome Measures (SOMs)

State: Florida

SOM 1 - Percent of family satisfaction with access to care received in a patient-centered medical home and primary care for children that have special health care needs

Measure Status:	Active
State Provided Data	
	2020
Annual Objective	
Annual Indicator	72.7
Numerator	64
Denominator	88
Data Source	CYSHCN Internal Survey
Data Source Year	2021
Provisional or Final ?	Final

Annual Objectives					
	2022	**2023**	**2024**	**2025**	**2026**
Annual Objective	75.0	75.5	76.0	76.5	77.0

Field Level Notes for Form 10 SOMs:

None

Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)

State: Florida

ESM 1.1 - The number of interconception services provided to Healthy Start clients

Measure Status:					Active
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		27,000	44,000	44,500	45,000
Annual Indicator	25,558	43,507	26,508	54,553	62,509
Numerator					
Denominator					
Data Source	Well Family System	Well Family System	Well Family System	Well Family System	Well Family System
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	63,009.0	63,509.0	64,009.0	64,509.0	65,009.0	75,984.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: In 2017, Healthy Start Coalitions began reporting numbers in the new Well Family System. This caused the significant change in the indicator data, and required us to update the objectives.	
2.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**

	Field Note: The 2020 annual indicator exceeded 2020 annual objective. For this reason, the annual objectives were updated to be inline with the 2020 annual indicator.	
3.	**Field Name:**	**2022**
	Column Name:	**Annual Objective**
	Field Note: The 2020 annual indicator exceeded 2020 annual objective. For this reason, the annual objectives were updated to be inline with the 2020 annual indicator.	
4.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**
	Field Note: The 2020 annual indicator exceeded 2020 annual objective. For this reason, the annual objectives were updated to be inline with the 2020 annual indicator.	
5.	**Field Name:**	**2024**
	Column Name:	**Annual Objective**
	Field Note: The 2020 annual indicator exceeded 2020 annual objective. For this reason, the annual objectives were updated to be inline with the 2020 annual indicator.	
6.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**
	Field Note: The 2020 annual indicator exceeded 2020 annual objective. For this reason, the annual objectives were updated to be inline with the 2020 annual indicator.	
7.	**Field Name:**	**2026**
	Column Name:	**Annual Objective**
	Field Note: The 2020 annual indicator exceeded 2020 annual objective. For this reason, the annual objectives were updated to be inline with the 2020 annual indicator.	

ESM 3.1 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	78.9	78.1
Numerator	2,737	2,492
Denominator	3,469	3,191
Data Source	Florida CHARTS	Florida CHARTS
Data Source Year	2019	2020
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	79.4	80.0	80.5	81.0	81.6	82.1

Field Level Notes for Form 10 ESMs:

None

ESM 4.1 - The number of Florida hospitals achieving the Baby Steps to Baby Friendly hospital designation.

Measure Status:	Active

State Provided Data				
	2017	2018	2019	2020
Annual Objective			19	20
Annual Indicator			26	26
Numerator				
Denominator				
Data Source			Baby-Friendly USA	Baby-Friendly USA
Data Source Year			2019	2020
Provisional or Final ?			Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	27.0	29.0	30.0	32.0	33.0	37.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**
	Field Note: The 2020 annual indicator exceeded 2020 annual objective. For this reason, the annual objectives were updated to be inline with the 2020 annual indicator.	
2.	**Field Name:**	**2022**
	Column Name:	**Annual Objective**
	Field Note: The 2020 annual indicator exceeded 2020 annual objective. For this reason, the annual objectives were updated to be inline with the 2020 annual indicator.	
3.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**
	Field Note: The 2020 annual indicator exceeded 2020 annual objective. For this reason, the annual objectives were updated to be inline with the 2020 annual indicator.	
4.	**Field Name:**	**2024**
	Column Name:	**Annual Objective**
	Field Note: The 2020 annual indicator exceeded 2020 annual objective. For this reason, the annual objectives were updated to be inline with the 2020 annual indicator.	
5.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**
	Field Note: The 2020 annual indicator exceeded 2020 annual objective. For this reason, the annual objectives were updated to be inline with the 2020 annual indicator.	
6.	**Field Name:**	**2026**
	Column Name:	**Annual Objective**
	Field Note: The 2020 annual indicator exceeded 2020 annual objective. For this reason, the annual objectives were updated to be inline with the 2020 annual indicator.	

ESM 5.1 - The number of birthing hospitals that are Safe Sleep Certified

Measure Status:	Active

State Provided Data				
	2017	2018	2019	2020
Annual Objective			17	19
Annual Indicator			10	23
Numerator				
Denominator				
Data Source			Cribs for Kids	Cribs for Kids
Data Source Year			2019	2020
Provisional or Final ?			Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	25.0	27.0	29.0	31.0	33.0	37.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Data not available.	
2.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**
	Field Note: The 2020 annual indicator exceeded 2020 annual objective. For this reason, the annual objectives were updated to be inline with the 2020 annual indicator.	
3.	**Field Name:**	**2022**
	Column Name:	**Annual Objective**
	Field Note: The 2020 annual indicator exceeded 2020 annual objective. For this reason, the annual objectives were updated to be inline with the 2020 annual indicator.	
4.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**
	Field Note: The 2020 annual indicator exceeded 2020 annual objective. For this reason, the annual objectives were updated to be inline with the 2020 annual indicator.	
5.	**Field Name:**	**2024**
	Column Name:	**Annual Objective**
	Field Note: The 2020 annual indicator exceeded 2020 annual objective. For this reason, the annual objectives were updated to be inline with the 2020 annual indicator.	
6.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**
	Field Note: The 2020 annual indicator exceeded 2020 annual objective. For this reason, the annual objectives were updated to be inline with the 2020 annual indicator.	
7.	**Field Name:**	**2026**
	Column Name:	**Annual Objective**
	Field Note: The 2020 annual indicator exceeded 2020 annual objective. For this reason, the annual objectives were updated to be inline with the 2020 annual indicator.	

ESM 8.1.1 - The cumulative total of Florida school districts that have ever been awarded the evidence-based Florida Healthy School District recognition.

Measure Status:	Active

State Provided Data				
	2017	2018	2019	2020
Annual Objective			54	55
Annual Indicator			49	49
Numerator				
Denominator				
Data Source			Safe and Healthy Schools Florida	Safe and Healthy Schools Florida
Data Source Year			2019	2020
Provisional or Final ?			Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	56.0	57.0	58.0	59.0	60.0	61.0

Field Level Notes for Form 10 ESMs:

None

ESM 8.2.1 - The cumulative total of Florida school districts that have ever been awarded the evidence-based Florida Healthy School District recognition.

Measure Status:	Active

State Provided Data	
	2020
Annual Objective	
Annual Indicator	49
Numerator	
Denominator	
Data Source	Safe and Healthy Schools Florida
Data Source Year	2020
Provisional or Final ?	Final

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	56.0	57.0	58.0	59.0	61.0

Field Level Notes for Form 10 ESMs:

None

ESM 9.1 - The number of students who participate in an evidence-based program that promotes positive youth development and non-violence intervention skills

Measure Status:	Active

State Provided Data				
	2017	2018	2019	2020
Annual Objective			13,100	13,500
Annual Indicator			12,625	13,205
Numerator				
Denominator				
Data Source			FDOH - Adolescent Health Program	FDOH - Adolescent Health Program
Data Source Year			2019	2020
Provisional or Final ?			Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	13,900.0	14,300.0	14,700.0	15,100.0	15,500.0	15,900.0

Field Level Notes for Form 10 ESMs:

None

ESM 11.1 - Number of DOH team members, providers (pediatric, family practice, and adult), families, family partners, and other partners serving CYSHCN in Florida receiving education or technical assistance about the patient-centered medical home model and relat

Measure Status:	Active
State Provided Data	
	2020
Annual Objective	
Annual Indicator	1,847
Numerator	
Denominator	
Data Source	CMS Public Health Detailing activity log
Data Source Year	2020
Provisional or Final ?	Final

Annual Objectives					
	2022	**2023**	**2024**	**2025**	**2026**
Annual Objective	0.0	0.0	0.0	0.0	0.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: We are not changing annual objectives at this time as it was a one-time dedicated campaign and we want to continue to monitor.	
2.	**Field Name:**	**2022**
	Column Name:	**Annual Objective**
	Field Note: We are not changing annual objectives at this time as it was a one-time dedicated campaign and we want to continue to monitor.	
3.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**
	Field Note: We are not changing annual objectives at this time as it was a one-time dedicated campaign and we want to continue to monitor.	
4.	**Field Name:**	**2024**
	Column Name:	**Annual Objective**
	Field Note: We are not changing annual objectives at this time as it was a one-time dedicated campaign and we want to continue to monitor.	
5.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**
	Field Note: We are not changing annual objectives at this time as it was a one-time dedicated campaign and we want to continue to monitor.	
6.	**Field Name:**	**2026**
	Column Name:	**Annual Objective**
	Field Note: We are not changing annual objectives at this time as it was a one-time dedicated campaign and we want to continue to monitor.	

ESM 11.2 - Percentage of caregivers of CYSHCN in Florida who perceive themselves as a partner in their child's care.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	71.0	72.0	73.0	74.0	75.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
Unable to report this year; awaiting updated National Survey Data.

ESM 11.3 - Percentage of providers in underserved geographic areas that received formal technical assistance through the UCF HealthARCH program that became designated patient-centered medical homes.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	0.0	0.0	0.0	0.0	0.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Unable to report this year (due to COVID challenges, will report updated data points in next application/report).	
2.	**Field Name:**	**2022**
	Column Name:	**Annual Objective**
	Field Note: Unable to report this year (due to COVID challenges, will report updated data points in next application/report).	
3.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**
	Field Note: Unable to report this year (due to COVID challenges, will report updated data points in next application/report).	
4.	**Field Name:**	**2024**
	Column Name:	**Annual Objective**
	Field Note: Unable to report this year (due to COVID challenges, will report updated data points in next application/report).	
5.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**
	Field Note: Unable to report this year (due to COVID challenges, will report updated data points in next application/report).	
6.	**Field Name:**	**2026**
	Column Name:	**Annual Objective**
	Field Note: Unable to report this year (due to COVID challenges, will report updated data points in next application/report).	

ESM 11.4 - Number of Adult Care Providers/Practices that report accepting CYSHCN transitioning to adult care.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	0.0	0.0	0.0	0.0	0.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Unable to report this year (developing survey now and will report updated data point in next application/report).	
2.	**Field Name:**	**2022**
	Column Name:	**Annual Objective**
	Field Note: Unable to report this year (developing survey now and will report updated data point in next application/report).	
3.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**
	Field Note: Unable to report this year (developing survey now and will report updated data point in next application/report).	
4.	**Field Name:**	**2024**
	Column Name:	**Annual Objective**
	Field Note: Unable to report this year (developing survey now and will report updated data point in next application/report).	
5.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**
	Field Note: Unable to report this year (developing survey now and will report updated data point in next application/report).	
6.	**Field Name:**	**2026**
	Column Name:	**Annual Objective**
	Field Note: Unable to report this year (developing survey now and will report updated data point in next application/report).	

ESM 14.1.1 - The number of Smoking Cessation Reduction in Pregnancy Treatment (SCRIPT) services provided to Healthy Start clients

Measure Status:	Active

State Provided Data				
	2017	2018	2019	2020
Annual Objective			7,000	7,250
Annual Indicator			9,736	8,020
Numerator				
Denominator				
Data Source			Well Family System	Well Family System
Data Source Year			2019	2020
Provisional or Final ?			Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	8,270.0	8,520.0	8,770.0	9,020.0	9,270.0	9,850.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**
	Field Note: The 2020 annual indicator exceeded the 2020 annual objective. For this reason, the annual objective were update to be inline with the 2020 annual indicator.	
2.	**Field Name:**	**2022**
	Column Name:	**Annual Objective**
	Field Note: The 2020 annual indicator exceeded the 2020 annual objective. For this reason, the annual objective were update to be inline with the 2020 annual indicator.	
3.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**
	Field Note: The 2020 annual indicator exceeded the 2020 annual objective. For this reason, the annual objective were update to be inline with the 2020 annual indicator.	
4.	**Field Name:**	**2024**
	Column Name:	**Annual Objective**
	Field Note: The 2020 annual indicator exceeded the 2020 annual objective. For this reason, the annual objective were update to be inline with the 2020 annual indicator.	
5.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**
	Field Note: The 2020 annual indicator exceeded the 2020 annual objective. For this reason, the annual objective were update to be inline with the 2020 annual indicator.	
6.	**Field Name:**	**2026**
	Column Name:	**Annual Objective**
	Field Note: The 2020 annual indicator exceeded the 2020 annual objective. For this reason, the annual objective were update to be inline with the 2020 annual indicator.	

Form 10
Evidence-Based or -Informed Strategy Measures (ESMs) (2016-2020 Needs Assessment Cycle)

2016-2020: ESM 11.2 - Percent of satisfaction of access to care for families of children with special health care needs who received care in a patient centered medical home or by a primary care provider.

Measure Status:			**Active**	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			50	80
Annual Indicator			80.6	72.7
Numerator			25	64
Denominator			31	88
Data Source			CMS Internal Survey	CMS Internal Survey
Data Source Year			2020	2021
Provisional or Final ?			Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: 2019 was a documented baseline. Due to COVID-19, the 2020 survey had a low yield (N=31) but captured satisfaction at 80%, updated annual objectives.	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: 2019 was a documented baseline. Due to COVID-19, the 2020 survey had a low yield (N=31) but captured satisfaction at 80%, updated annual objectives.	

2016-2020: ESM 12.2 - Percent of satisfaction of access for youth with special health care needs who report having access to community-based resources necessary to make transition to adult health care.

Measure Status:			**Active**	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			50	55
Annual Indicator			27.8	4.5
Numerator			5	2
Denominator			18	44
Data Source			CSHCN	CMS Internal Survey
Data Source Year			2019	2021
Provisional or Final ?			Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
Due to COVID there was a low response rate (N=2), with 44% (N=4) neither agreeing or disagreeing.

Form 10
State Performance Measure (SPM) Detail Sheets

State: Florida

SPM 1 - The percentage of children that need mental health services that actually receive mental health services.
Population Domain(s) – Children with Special Health Care Needs

Measure Status:	Active
Goal:	Increase the percentage of children with a mental/behavioral condition who receive treatment.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of children that needed mental health services that actually received mental health services. **Denominator:** Number of children that needed mental health services.
Data Sources and Data Issues:	National Survey of Children's Health
Significance:	Linking children who have mental health and behavioral health conditions to timely and appropriate treatment will improve health outcomes and improve the child's ability to function optimally at home, at school, and in society

SPM 2 - The percentage of low-income children under age 21 who access dental care.
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	To increase the number of eligible low-income children who receive dental care.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of Medicaid eligible children (unduplicated) age 0-20 receiving any dental or oral health service. **Denominator:** Total number of Medicaid eligible children age 0-20.
Data Sources and Data Issues:	Agency for Health Care Administration (Medicaid DSS)
Significance:	Oral health is vitally important to overall health and well-being. Oral health is much more than just healthy teeth. Oral health is a state of being free from chronic mouth and facial pain, oral and throat cancer, oral sores, birth defects, periodontal disease, tooth decay and tooth loss, and other disease and disorders that affect the oral cavity. Good oral health also includes the ability to carry on basic human functions such as chewing, swallowing, speaking, smiling, and singing. These functions are critical in our communication with others and interaction with the world. Oral health is also firmly linked with overall health. Research has shown a link to diabetes, heart and lung disease, stroke, respiratory illnesses, and conditions of pregnant women including the delivery of pre-term and low birth weight infants. Changes in the mouth often are the first signs of problems elsewhere in the body, such as infectious diseases, immune disorders, nutritional deficiencies, and cancer. Maintaining good oral and physical health requires a multi-faceted approach including a healthy diet, proper exercise, access to health care professionals, and public health initiatives such as fluoridated community water and preventive dental services including dental sealants. Dental disease is largely preventable through effective health promotion and dental disease prevention programs. Collaborative partnerships among individuals, communities, health care providers and governing bodies are necessary to achieve optimal oral health in Florida.

SPM 3 - The percentage of parents who read to their young child age 0-5 years
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	To increase the number of parents who read to their child age 0-5.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of children aged 0 to 5 years whose parents report that someone in their family read to the child every day in the past week. **Denominator:** Number of children aged 0 to 5 years.
Data Sources and Data Issues:	National Survey of Children's Health
Significance:	Encouraging parents to read to their child has a positive impact on children, including but not limited to, increased positive parenting, improvement in the parent-child bond, and improved language development in children.

Form 10
State Performance Measure (SPM) Detail Sheets (2016-2020 Needs Assessment Cycle)

2016-2020: SPM 4 - The percentage of individuals who received workforce development that reported improved public health competency and capacity.
Population Domain(s) – Children with Special Health Care Needs

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Establish a sustainable public health workforce, improving competency and capacity of the public health system serving Children and Youth with Special Health Care Needs.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of Title V staff, families and partners participating in a sponsored workforce development event reporting improved public heath competency and capacity.</td></tr>
<tr><td>Denominator:</td><td>Number of Title V staff, families and partners that participated in a sponsored workforce development event.</td></tr>
</table>
</td></tr>
<tr><td>Healthy People 2020 Objective:</td><td>PHI-2 Increase the proportion of Tribal, State, and local public health personnel who receive continuing education consistent with the Core Competencies for Public Health Professionals</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Office of Children’s Medical Services Managed Care Plan and Specialty Programs Data</td></tr>
<tr><td>Significance:</td><td>The development and implementation of a learning culture, with training and support activities, will improve competency and capacity of the public health agency’s workforce. Necessary strategic skills development positions the Title V workforce to meet the evolving needs of the public. This includes improved access to care, quality improvement tools to drive transformation, and the promotion of integration within public health and across organizational boundaries including primary care, the community based service delivery systems and other key partnerships.</td></tr>
</table>

Form 10
State Outcome Measure (SOM) Detail Sheets

State: Florida

SOM 1 - Percent of family satisfaction with access to care received in a patient-centered medical home and primary care for children that have special health care needs
Population Domain(s) – Children with Special Health Care Needs

Measure Status:	Active
Goal:	To increase the percent of families that report satisfaction with access to care received in a patient-centered medical home and primary care for children that have special health care needs.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of families that reported satisfaction with access to care received in a patient-centered medical home and primary care for children that have special health care needs. **Denominator:** Total number surveyed
Healthy People 2030 Objective:	MICH-19 Increase the proportion of children and adolescents who receive care in a medical home
Data Sources and Data Issues:	CMS Internal Survey
Significance:	Patient experience is a main component for achieving high quality care. Systematic review of evidence demonstrates positive association between patient experience and clinical effectiveness. The results of this measure will provide family voice in perception of satisfaction to help drive quality improvement activities

Form 10
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: Florida

ESM 1.1 - The number of interconception services provided to Healthy Start clients
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	To increase the number of interconception care services provided to clients in the Healthy Start Program
Definition:	**Unit Type:** Count **Unit Number:** 80,000 **Numerator:** Number of interconception services provided to Healthy Start clients **Denominator:**
Data Sources and Data Issues:	Department of Health, Health Management System
Significance:	Interconception care helps providers identify and modify biomedical, behavioral, and social risks to a woman's health or pregnancy outcome through prevention and management. The goal to improve the woman's health and help reduce health risks to her future baby, resulting in improved outcomes for newborns and mothers.

ESM 3.1 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)
NPM 3 – Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Measure Status:	Active
Goal:	Increase the availability of Level III beds in NICUs.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of very low birthweight infants **Denominator:** Number of Level III NICU beds
Data Sources and Data Issues:	Florida CHARTS
Significance:	To ensure that the state has the capacity for all very low birthweight infants to be born in a Level III NICU.

ESM 4.1 - The number of Florida hospitals achieving the Baby Steps to Baby Friendly hospital designation. NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	To increase the number of Florida hospitals achieving the Baby Steps to Baby Friendly hospital designation.
Definition:	**Unit Type:** Count **Unit Number:** 100 **Numerator:** The number of Florida hospitals achieving the Baby Steps to Baby Friendly hospital designation. **Denominator:**
Data Sources and Data Issues:	Baby Steps to Baby Friendly USA multi-year tracker
Significance:	Baby Friendly birthing hospitals offer an optimal level of care for infant feeding and mother/baby bonding. They provide mothers with the information, confidence, and skills necessary to successfully initiate and continue breastfeeding their babies or feed formula safely. Breastfeeding provides the most complete nutrition possible, the optimal mix of nutrients and antibodies necessary for each baby to thrive. Studies have shown that breastfed children have far fewer and less serious illnesses than those who never receive breast milk, including a reduced risk of SIDS, childhood cancers, and diabetes. Recent studies show that women who breastfeed enjoy decreased risks of breast and ovarian cancer, anemia, and osteoporosis. Both mother and baby enjoy the emotional benefits of the very special and close relationship formed through breastfeeding.

ESM 5.1 - The number of birthing hospitals that are Safe Sleep Certified
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active
Goal:	To increase the number of Florida birthing hospitals that are Safe Sleep Certified.
Definition:	**Unit Type:** Count **Unit Number:** 100 **Numerator:** Number of Florida birthing hospitals in Florida that are Safe Sleep Certified **Denominator:**
Data Sources and Data Issues:	Cribs for Kids in Florida
Significance:	Safe sleep guidelines are endorsed by the American Academy of Pediatrics, the National Institute of Health, the CDC and by other nationally recognized programs. A hospital safe sleep certification process would ensure that participating hospitals develop a policy to support safe sleep efforts and that trusted hospital professionals provide consistent safe sleep messaging to parents.

ESM 8.1.1 - The cumulative total of Florida school districts that have ever been awarded the evidence-based Florida Healthy School District recognition.
NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Measure Status:	Active
Goal:	Increase the number of students who attend schools in Florida Healthy School Districts.
Definition:	**Unit Type:** Count **Unit Number:** 100 **Numerator:** The number of school districts that apply for the evidence-based Florida Healthy School District recognition. **Denominator:**
Data Sources and Data Issues:	Florida Partnership for Healthy Schools
Significance:	The Florida Healthy School District Self-Assessment Tool was developed by experts from state agencies, school districts, and community partners to assist districts in achieving the highest standards in infrastructure and the eight component areas of the Centers for Disease Control and Prevention's (CDC) Coordinated School Health (CSH) model. It was piloted, field tested and fully vetted prior to its release in 2009. Districts that earn recognition as a Florida Healthy School District have made a high level commitment to meeting the health needs of students and staff by removing barriers to learning and maximizing district resources through the implementation of the CSH/Whole School, Whole Community, Whole Child (WSCC) approach including physical education and physical activity.

ESM 8.2.1 - The cumulative total of Florida school districts that have ever been awarded the evidence-based Florida Healthy School District recognition.
NPM 8.2 – Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day

Measure Status:	Active
Goal:	Increase the number of students who attend schools in Florida Healthy School Districts (ages 12-17).
Definition:	<table><tr><td>**Unit Type:**</td><td>Count</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>The number of school districts that apply for the evidence-based Florida Healthy School District recognition.</td></tr><tr><td>**Denominator:**</td><td></td></tr></table>
Data Sources and Data Issues:	Florida Partnership for Healthy Schools
Evidence-based/informed strategy:	ESM 8.2.1
Significance:	The Florida Healthy School District Self-Assessment Tool was developed by experts from state agencies, school districts, and community partners to assist districts in achieving the highest standards in infrastructure and the eight component areas of the Centers for Disease Control and Prevention's (CDC) Coordinated School Health (CSH) model. It was piloted, field tested and fully vetted prior to its release in 2009. Districts that earn recognition as a Florida Healthy School District have made a high level commitment to meeting the health needs of students and staff by removing barriers to learning and maximizing district resources through the implementation of the CSH/Whole School, Whole Community, Whole Child (WSCC) approach including physical education and physical activity.

ESM 9.1 - The number of students who participate in an evidence-based program that promotes positive youth development and non-violence intervention skills
NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Measure Status:	Active
Goal:	To increase the number of students who participate in an evidence based program that promotes positive youth development and non-violence intervention skills.
Definition:	**Unit Type:** Count **Unit Number:** 50,000 **Numerator:** The number of students completing Positive Youth Development programs and the number of students participating in the Green Dot high School strategy overview and bystander training.. **Denominator:**
Data Sources and Data Issues:	Programmatic sign in sheets/class rosters and the Florida Department of Health Sexual Violence Data Registry
Significance:	Positive Youth Development is an evidence-based strategy that focuses on asset-building and goal-setting as a means of risk reduction. PYD programs have been proven to positively impact teen birth, healthy relationships, college and career preparation, and overall self-esteem. The PYD approach supports the physical, emotional, social and mental health of adolescents. Research shows risk factors such as poor social competence, low academic achievement, impulsiveness, truancy, and poverty increase an individual's risk of violence. Developing youth life skills, improving their participation and performance in school, and increasing their prospects for employment can help protect them from violence, both in childhood and later in life. Developing life skills for intervention and self-empowerment can help young people avoid violence, by improving their social and emotional competencies and teaching them how to deal effectively and non-violently with conflict.

ESM 11.1 - Number of DOH team members, providers (pediatric, family practice, and adult), families, family partners, and other partners serving CYSHCN in Florida receiving education or technical assistance about the patient-centered medical home model and relat
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	Increase the number of stakeholders serving CYSHCN, who received education and technical assistance about the patient-centered medical home model and related topics that impact the health and wellness of CYSHCN
Definition:	**Unit Type:** Count **Unit Number:** 10,000 **Numerator:** Number of education or technical assistance activities provided to stakeholders about the patient-centered medical home model and related topics that impact the health and wellness of CYSHCN **Denominator:**
Data Sources and Data Issues:	CMS Title V Public Health Detailing activity tracker
Evidence-based/informed strategy:	CYSHCN require health services beyond what is typically required. Florida is behind the national average for care that meets medical home criteria.
Significance:	Providers, communities and families need to be informed and have access to technical assistance on patient-centered medical home resources and other related topics that impact the health and wellness of CYSHCN.

ESM 11.2 - Percentage of caregivers of CYSHCN in Florida who perceive themselves as a partner in their child's care.
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	Increase the percentage of caregivers of CYSHCN who perceive themselves as partners in their child's care by 5% annually from identified baseline.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of caregivers of CYSHCN that perceive themselves as partners in their child's care. **Denominator:** Total number surveyed
Data Sources and Data Issues:	National Survey of Children's Health
Evidence-based/informed strategy:	CYSHCN require quality care this is patient and family centered.
Significance:	Health equity starts with patient and family engagement at all levels of service delivery.

ESM 11.3 - Percentage of providers in underserved geographic areas that received formal technical assistance through the UCF HealthARCH program that became designated patient-centered medical homes.
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	Increase the percentage of underserved geographic areas that have at least on pediatric practice this is designates as a PCMH by 20% annually.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** New pediatric patient centered medical homes in underserved geographic areas **Denominator:** Baseline number of pediatric patients centered medical homes in underserved geographic areas.
Data Sources and Data Issues:	CMS Title V data source geo-mapping
Evidence-based/informed strategy:	Health inequities in rural areas are exacerbated by a lack of resources.
Significance:	CYSHCN require a level of quality care that is seen in a patient centered medical home model.

ESM 11.4 - Number of Adult Care Providers/Practices that report accepting CYSHCN transitioning to adult care.
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	Increase the number of identified Adult Care Providers/Practices that are PCMH's that accept CYSCHN transitioning to Adult Care.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of surveyed adult care providers/practices that are PCMH that reported yes they accept CYHSCN transition to adult care. **Denominator:** Total number of surveyed adult care providers/practices that are PCMH.
Data Sources and Data Issues:	CMS Title V CYSHCN survey results
Evidence-based/informed strategy:	CYHSCN that are transitioning to Adult Care, need access to quality care that is comprehensive, patient centered, coordinated, accountable and continuous.
Significance:	CYHSCN that are transitioning to Adult Care, need access to quality care that is comprehensive, patient centered, coordinated, accountable and continuous.

ESM 14.1.1 - The number of Smoking Cessation Reduction in Pregnancy Treatment (SCRIPT) services provided to Healthy Start clients
NPM 14.1 – Percent of women who smoke during pregnancy

Measure Status:	Active
Goal:	To increase the number of pregnant women who receive Smoking Cessation Reduction in Pregnancy Treatment (SCRIPT) services.
Definition:	**Unit Type:** Count **Unit Number:** 50,000 **Numerator:** Number of SCRIPT services provided to Healthy Start clients. **Denominator:**
Data Sources and Data Issues:	Well Family System
Significance:	Smoking during pregnancy creates risks for adverse outcomes.

Form 10
Evidence-Based or -Informed Strategy Measure (ESM) (2016-2020 Needs Assessment Cycle)

2016-2020: ESM 11.2 - Percent of satisfaction of access to care for families of children with special health care needs who received care in a patient centered medical home or by a primary care provider.
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To increase the percentage of family satisfaction with access to care received in a patient-centered medical home and/or primary care for children that have special health care needs.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Percent of families reporting at least an 80% satisfaction rate</td></tr>
<tr><td>Denominator:</td><td>All families surveyed</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Survey: University Florida Institute for Child Health Policy</td></tr>
<tr><td>Significance:</td><td>Patient experience is main component of achieving high-quality care. Systematic review of studies demonstrates positive association between patient experience and clinical effectiveness and patient safety, decreasing health care costs. The identified priority need included primary care, and not just patient-centered medical home, which necessitated the inclusion of this in the measure. The results of this measure will help drive quality improvement activities, driven by family input, to improve access.</td></tr>
</table>

2016-2020: ESM 12.2 - Percent of satisfaction of access for youth with special health care needs who report having access to community-based resources necessary to make transition to adult health care.
2016-2020: NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To increase the percent of youth satisfaction with access to community based resources necessary to make transition to adult health care.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of youth you have access to community-based resources to make transition to adult health care.</td></tr>
<tr><td>Denominator:</td><td>All youth surveyed</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Survey: University of Florida Institute for Child Health Policy</td></tr>
<tr><td>Significance:</td><td>The successful transition of youth and young adults with special health care needs, is essential to individual self-determination and self-management. Youth perception of satisfaction with access to community based resources needed to make a transition to adult health care will help drive quality measures to ensure their transition needs are met from their perspective. This will help drive program development and quality improvement activities to support the achievement of successful outcomes.</td></tr>
</table>

Form 11
Other State Data

State: Florida

The Form 11 data are available for review via the link below.

Form 11 Data

Form 12
MCH Data Access and Linkages

State: Florida

Annual Report Year 2020

	Access				Linkages	
Data Sources	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
1) Vital Records Birth	Yes	Yes	Daily	0		
2) Vital Records Death	Yes	Yes	Daily	0	Yes	
3) Medicaid	Yes	Yes	Annually	12	No	
4) WIC	Yes	Yes	Less Often than Annually	0	No	
5) Newborn Bloodspot Screening	Yes	Yes	Daily	0	Yes	
6) Newborn Hearing Screening	Yes	Yes	Daily	0	Yes	
7) Hospital Discharge	Yes	Yes	Quarterly	6	Yes	
8) PRAMS or PRAMS-like	Yes	Yes	Annually	18	Yes	

Form Notes for Form 12:

None

Field Level Notes for Form 12:

None